**PGH Form No. Q-074031**

**PHILIPPINE GENERAL HOSPITAL**

**The National University Hospital**

**University of the Philippines Manila**

**Taft Avenue, Manila**

***PHIC-Accredited Health Care Provider***

***ISO 9001 Certified***

**Rev. 00 Eff. 17 January 2024**

Logo

Description automatically generated with medium confidence

**CERTIFICATION ON DUTY SCHEDULE OF MEDICAL SPECIALIST**

**EMPLOYEE INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name  (Last, Given, Middle) |  | Specific Work Area/Section |  |
| Position |  | Type of Schedule | Admin Hours Shifting Schedule |
| Dept./Div./Unit/Office |  | Status of Appt. | Permanent Temporary |

**DUTY SCHEDULE OF THE APPLICANT FOR LIMITED PRACTICE OF PROFESSION**

**A.PGH DUTY**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Duties and Responsibilities** | **Duty Schedule(hour/s)**  **(e.g 8:00am to 12:00 nn)** | | | | | | | **Total Work hours per week** | **Remarks** |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| Service |  |  |  |  |  |  |  |  |  |
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| Education & Training |  |  |  |  |  |  |  |  |  |
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| Others |  |  |  |  |  |  |  |  |  |
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**B. LIMITED PRACTICE OF PROFESSION DUTY**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Duties and Responsibilities** | **Duty Schedule(hour/s)**  **(e.g 8:00am to 12:00 nn)** | | | | | | | **Total Work hours per week** | **Name of Hospital/Clinic/Enterprise and Exact Location** |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| Service |  |  |  |  |  |  |  |  |  |
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**I hereby certify/endorse that the information given are true, correct, and complete pursuant to the provisions of pertinent laws, rules, and regulations. Further, I agree that any misinterpretation made**

**in this form shall cause the filing of administrative/criminal case/s against the undersigned.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Submitted by: |  | | | Endorsed by: | |
|  | |  | | |  | |
| Signature over printed name of applicant for Limited Practice of Profession and Date | | |  | | Signature over printed name of Dept Chair/Div Chief/Head of Office/Unit and Date | |

**HRDD ACTION**

Received and Noted

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature over Printed Name of BWRS Staff and Date