

PHILIPPINE HOSPITAL ASSOCIATION

#14 Kamias Road, Quezon City 1102

APPLICATION FOR REGULAR MEMBERSHIP (For Level III/Level IV Hospitals & Medical Centers)

| | | | | | | | | | | | | | | | | | |
|--|---|--|--|------------------|-------------------------|---------------------------|-------------------------|--------------|---------------------------|-----------------------------|---------------------|-------------------|------------------------|----------------------|--------------------------|----------------------------|--|
| Name of Hospital | | Date Established | | | | | | | | | | | | | | | |
| Address | | Tel. No. | | | | | | | | | | | | | | | |
| Owner | | Chairman of the Board (for corporation) | | | | | | | | | | | | | | | |
| Medical/Hospital Director | | Administrator | | | | | | | | | | | | | | | |
| Chief of Hospital (for Government Hospital) | | Or Provincial Health Officer | | | | | | | | | | | | | | | |
| Type of Hospital (General or Special, ex. Maternity, etc.) | | | | | | | | | | | | | | | | | |
| Bed Capacity (Excluding Newborn Bassinets) | | Number of Newborn Bassinets | | | | | | | | | | | | | | | |
| Average Daily Census (Inpatient) | | Average Daily Consultants (Outpatient) | | | | | | | | | | | | | | | |
| Ownership: _____ Government (National, Provincial, City, Others) _____ Medicare Community Hospital _____ Private (Proprietary, Religious, Military, Corporation, Foundation) _____ Others (Specify) _____ | | | | | | | | | | | | | | | | | |
| DOH License No. | | Issued on: | | | | | | | | | | | | | | | |
| Clinical Services, Diagnostic & Therapeutic Facilities available: (PLEASE CHECK) <table style="width: 100%; margin-top: 10px;"> <tr> <td>_____ Medicine</td> <td>_____ X-ray, Diagnostic</td> </tr> <tr> <td>_____ Surgery</td> <td>_____ X-ray, Therapy</td> </tr> <tr> <td>_____ EENT</td> <td>_____ Clinical Laboratory</td> </tr> <tr> <td>_____ Obstetrics and Gyn</td> <td>_____ Pharmacy</td> </tr> <tr> <td>_____ Pediatrics</td> <td>_____ Physical Therapy</td> </tr> <tr> <td>_____ Anesthesiology</td> <td>_____ Outpatient Service</td> </tr> <tr> <td>_____ Others Specify _____</td> <td></td> </tr> </table> | | | | _____ Medicine | _____ X-ray, Diagnostic | _____ Surgery | _____ X-ray, Therapy | _____ EENT | _____ Clinical Laboratory | _____ Obstetrics and Gyn | _____ Pharmacy | _____ Pediatrics | _____ Physical Therapy | _____ Anesthesiology | _____ Outpatient Service | _____ Others Specify _____ | |
| _____ Medicine | _____ X-ray, Diagnostic | | | | | | | | | | | | | | | | |
| _____ Surgery | _____ X-ray, Therapy | | | | | | | | | | | | | | | | |
| _____ EENT | _____ Clinical Laboratory | | | | | | | | | | | | | | | | |
| _____ Obstetrics and Gyn | _____ Pharmacy | | | | | | | | | | | | | | | | |
| _____ Pediatrics | _____ Physical Therapy | | | | | | | | | | | | | | | | |
| _____ Anesthesiology | _____ Outpatient Service | | | | | | | | | | | | | | | | |
| _____ Others Specify _____ | | | | | | | | | | | | | | | | | |
| Total Number of Personnel (Excluding those not in hospital payroll) (PLEASE INDICATE IN FIGURES/NUMBERS) <table style="width: 100%; margin-top: 10px;"> <tr> <td>_____ Physicians</td> <td>_____ Midwives</td> </tr> <tr> <td>_____ Resident Physicians</td> <td>_____ X-ray Technicians</td> </tr> <tr> <td>_____ Nurses</td> <td>_____ Aids</td> </tr> <tr> <td>_____ Medical Technologists</td> <td>_____ Other workers</td> </tr> <tr> <td>_____ Pharmacists</td> <td></td> </tr> <tr> <td>_____ Dietitians</td> <td></td> </tr> </table> Consulting or Visiting Staff: _____ Physicians (Including those not in the hospital payroll) | | | | _____ Physicians | _____ Midwives | _____ Resident Physicians | _____ X-ray Technicians | _____ Nurses | _____ Aids | _____ Medical Technologists | _____ Other workers | _____ Pharmacists | | _____ Dietitians | | | |
| _____ Physicians | _____ Midwives | | | | | | | | | | | | | | | | |
| _____ Resident Physicians | _____ X-ray Technicians | | | | | | | | | | | | | | | | |
| _____ Nurses | _____ Aids | | | | | | | | | | | | | | | | |
| _____ Medical Technologists | _____ Other workers | | | | | | | | | | | | | | | | |
| _____ Pharmacists | | | | | | | | | | | | | | | | | |
| _____ Dietitians | | | | | | | | | | | | | | | | | |
| Number of inpatients during the previous Year (excluding newborn) | Number of outpatient consultations during the previous year | Number of newborn during the previous year | | | | | | | | | | | | | | | |
| Total operating expenses for the previous year | | Gross payroll for the previous year | | | | | | | | | | | | | | | |
| P | | P | | | | | | | | | | | | | | | |

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|---|----------------------------------|
| Do you have a School of: (Please Check) | If YES, state number of students |
| <input type="checkbox"/> Nursing <input type="checkbox"/> Midwifery <input type="checkbox"/> Allied Services (Please specify) | _____ _____ _____ |

| | |
|--|------------------------|
| Is the hospital accredited by a Special Board? (ex. Philippine College of Surgeons) (Please check) | (Please specify) _____ |
| <input type="checkbox"/> For Service <input type="checkbox"/> For Training | |

In applying for membership, the Management of the Hospital shall abide by the Constitution and By-Laws of the Association, and its official representatives of the Association and help promote the objectives and purpose for which it stands.

The following are hereby designated as the official representatives of the hospital to the Association.

| | |
|------------------------------|--|
| _____ | _____ |
| Name/Position | Name of Hospital |
| | BY: |
| _____ | _____ |
| Name/Position (Alternate) | Medical Director/Administrator/Chief of Hospital |

Enclosure:
 DOH License (1) Xerox copy
 Evaluation Report of Chapter's/Council's President

| | |
|--------------------------------|---|
| FOR PHA CHAPTER/COUNCIL | |
| Date: _____ | Endorsed by: _____ |
| | PRESIDENT (PHA Chapter/Council – Specify) |

| | |
|----------------------|---|
| FOR PHA BOARD | |
| Date: _____ | Recommending Approval: _____ |
| | CHAIRMAN, Membership & Accreditation Committee |

| | | |
|-----------------|------------------------|--------------------|
| Approved | Action Deferred | Disapproved |
|-----------------|------------------------|--------------------|

By the Board of Directors at the meeting held on _____ 200_____

Secretary