



Republic of the Philippines
Department of Health
**DEPLOYMENT PROGRAM / PROJECT
APPLICATION FORM**



Paste a recent 1" x 1" photograph (taken within the last 6 months) in this box.

Print legibly and use separate sheet if necessary. Place ✓marks in appropriate boxes. Only accomplished application forms will be processed.

POSITION APPLIED FOR:

- | | |
|---|--|
| <input type="checkbox"/> Physician Augmentation Deployment Project (PADP) | <input type="checkbox"/> Medical Technologists Deployment Project (MTDP) |
| <input type="checkbox"/> UHC Implementers Deployment Project (UHCIDP) | <input type="checkbox"/> Pharmacist Deployment Project (PDP) |
| <input type="checkbox"/> Nurse Deployment Project (NDP) | <input type="checkbox"/> Public Health Associates Deployment Project (PHADP) |
| <input type="checkbox"/> Rural Health Midwives Placement Program (RHMP) | <input type="checkbox"/> Family Health Associate Deployment Project (FHADP) |
| <input type="checkbox"/> Dentist Deployment Project (DDP) | |

Personal Background

Name		Surname		First Name		Middle Name		
Date of Birth (mm/dd/yyyy)			Place of Birth			Dialect/s Spoken		
Age	Gender		Civil Status			Nationality	Religion	
	<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated					

Permanent Address				Tel. # / Mobile Number/s	
Street				District	
Municipality/City		Province		Email Address	

Educational Background

School Attended	Inclusive Dates	Honor(s) / Distinction Received/Papers made or Published
Primary		
Secondary		
Tertiary (Degree Earned)		
Post Graduate		

Eligibility

CAREER SERVICE / RA 1080 (BOARD/BAR) UNDER SPECIAL LAWS / CES / CSEE	RATING	DATE OF EXAMINATION / CONFIRMATION	PLACE OF EXAMINATION / CONFIRMATION	LICENSE (if applicable)	
				NUMBER	REGISTRATION DATE

Employment Background

Position Title	Office/Company	Inclusive Dates	Status of Employment

(continue on separate sheet if necessary)

Community Involvement

Organization/Association	Type of Involvement	Inclusive Dates	Status of Involvement

(continue on separate sheet if necessary)

Trainings Attended related to Health

Title of Seminar/Conference/Workshop/Short Courses (Write in Full)	Inclusive Dates of Attendance (mm/dd/yyyy)		Number of Hours	Conducted / Sponsored by (Write in Full)
	FROM	TO		

(continue on separate sheet if necessary)