PHILIPPINE OBSTETRICAL AND GYNECOLOGICAL SOCIETY (Foundation), INC.
COMMITTEE ON MUTUAL ASSISTANCE PROGRAM

LIVING BENEFIT PROGRAM (LBP)
APPLICATION FORM

LBP Form 1

To be accomplished by the POGS MAP Member or member of the family:

Date of application ____
Name of Applicant ____
Category: Fellow______ Diplomate______ Junior______ Life_____ Associate___
Address ____
____
Age: _______________________ Date of Birth _____________________________
Contact Numbers ________________________Email address: ____________________________
Contact Person ________________________Relation to the member ___________________

____
Signature of applicant / Contact Person

To be accomplished by the Attending Physician:

Disability / Illness ____
Duration of Illness ____
Present Condition ____
____
Procedure(s) performed ____
____
Remarks ____
____
____

I HEREBY CERTIFY that the above information are true and correct to the best of my knowledge:

Name of Attending Physician: ____

License No. ____________ Signature _____________________ Date signed: _________________

- -

ACTION TAKEN

CMAP:

☐ **Recommending approval**

☐ **Disapproved**

By: ______________________________
CMAP Validating Officer
(Printed name over signature)

SIGNATURES:

____
CMAP Chair

____
POGS President