

**INFORMATION SHEET**

DIPLOMATE EXAMINATION CANDIDATES

Form
EC-02

<i>(Please Print)</i>			(Photo here)
▼ Surname:	▼ First name:	▼ Middle name:	
▼ Birth date: (mmddyy)	▼ Birth place:	▼ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
▼ Home Address: ▼	▼ Home phone no.: ()		
▼ Primary Clinic Address:	▼ Mobile phone no.:		
Preferred Mailing Address (Please Tick One) ▶: <input type="checkbox"/> Home <input type="checkbox"/> Clinic Clinic Phone ▶:			
Place(s) of Practice ▶:			
Medical School Graduated from ▶:		Year graduated ▶:	
Internship ▶:		Year attended ▶:	
PRC License no ▶:	Date Issued ▶:	Valid Until ▶:	
▼ Orthopaedic Residency Training :	▼ Inclusive dates of attendance :		
▼ Fellowship or Post Graduate Training:	▼ Inclusive dates of attendance :		
1.	1.		
2.	2.		
▼ Academic Appointments : (Institution)	▼ Rank/Position:		
1.			
2.			
▼ Medical Society Membership(s) :			
1.			
2.			
3.			
▼ Hospital Affiliations (Credentialed, if applicable):			
1.			
2.			
3.			
▼ Research Papers (Titles and where published, if applicable; Attach papers separately) :			
1.			
2.			
3.			