

**Arrangement in Sequence of Part II
Oral Examination Requirements
For Applicants with Deficiencies
(Resubmission of New Cases)**

PBOG resolution 2021.04.06.

An applicant should resubmit requirements within one year from a disapproved Part I or Part II application. Only new cases will be utilized for resubmission following stipulated PBOG recommendations.

CHECKLIST

Cover page – TITLE: “Requirements for Diplomate Part II” (RESUBMISSION Number ____) Name of Applicant _____ Date of Submission _____		
General Table of Contents – List of the sequence in which the requirements are arranged in the compilation; PAGE NUMBER is required on ALL pages.		
PBOG Letter to Applicant	Stating demerits or infractions and how to correct these, including replacement cases to submit	
Photocopy of Previous Application Form	Completely filled out Re-submission must be WITHIN ONE (1) YEAR from previous application.	
Certificates	Jurat Notarization (this is a CORE requirement). <i>Refer to Appendix E.</i>	
	Certificate of POGS Junior Membership (must be within the validity period of 5 years)	
	Certificate of Completion or Diploma of Residency Training.	
	Certificate of Good Standing from PMA or its component society.	
	Updated valid PRC ID.	

	<p>All other documents that are specified in the PBOG Letter</p> <p>Certification of authenticity of cases, from the Department Chair <u>AND</u> the Medical Director that submitted cases were admitted and performed by the applicant</p>	
<p>Cases</p>	<p>Create a tabulation for each category: major, minor, or major with discussion, depending on what the PBOG Letter specifies.</p> <p>Cases should be done as within two (2) years from the time of application, after residency training and with the applicant as the PRIMARY SURGEON (cases done during Fellowship are accepted).</p> <p>TABULATION OF CASES/PROCEDURES with seven columns (in ARIAL font 12 pt, landscape view)</p> <ul style="list-style-type: none"> • Tally number, Patient’s age and OB score, Date admitted, Date discharged, Hospital where procedure was done • Admitting Diagnosis • Pre-operative Diagnosis • Management, Operation/Procedure done, Anesthesia done, Date done • Indication for Surgery/Procedure (INCLUDE Justification if there is deviation from standard of care) DO NOT leave this column blank. DO NOT copy pre-operative diagnosis. • Final Diagnosis • Patient/Maternal/Fetal Outcome/Histopathology result 	
	<p>SUPPORTING DOCUMENTS for Major and Minor Cases – arranged following the sequence in “Tabulation of Cases/Procedures” and correctly labelled with the Tally Number stated in the tabulation (OB1, OB2, OB3 ...)</p> <ul style="list-style-type: none"> • Operative Record – applicant types the EXACT contents of the Operative Record, but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view) The type of anesthesia used and duration of surgery must be stated. • Operative Technique 	

	<ul style="list-style-type: none"> • Partogram (for all dystocia and failed induction cases) • Histopathology Report, if applicable - applicant types the EXACT contents of the histopathology report, with gross and microscopic descriptions but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view and stamped Certified True Copy by the Records Section) <p>Applicant to follow DATA PRIVACY POLICY: Typewritten copies of OR Technique (with findings) and Histopathology Report (if applicable in case/s) are submitted WITHOUT PATIENT IDENTIFIERS such as Name and Case number (anonymized data).</p>	
	<p>Supporting Documents for Major Cases with Discussion – arranged following the sequence in “Tabulation of Cases/Procedures” <i>Refer to Appendix J.</i></p> <ul style="list-style-type: none"> • Complete History and Physical Examination <ol style="list-style-type: none"> 1) Chief Complaint 2) History of Present Illness 3) Past History 4) Family History 5) Personal and Social History 6) Menstrual History 7) Obstetrical History 8) Systems Review 9) Condition on Admission 10) Physical Examination • Laboratory Examinations/Ancillary Procedures • Admitting Diagnosis • Pre-operative Diagnosis • Type of Operation; Operative Technique and Operative Findings • Post-operative Diagnosis (include necessary post-operative discussion) • Friedman’s Curve or Partogram (for dystocia cases) • Course in the Ward/Post-operative Management • Final Diagnosis • Discussion Proper: basis for diagnosis, differential diagnosis/diagnoses; justification for choice of 	

	<p>diagnostic tests; justification for choice of management, pre-operative management; discussion of operative findings, outcome and postoperative management, and future plans for the patient</p> <p>Discussion should be limited to ONE PAGE with a minimum of 500 words and a maximum of 600 words (written in ARIAL font 12 pt, single space, portrait view). It should be patient-focused/patient-centered with emphasis on the critical issues influencing the decision-making in the case.</p> <ul style="list-style-type: none"> • References/Bibliography – correct citation (superscripts on text), LATEST references and evidence from RECENT literature • Operative Record with Operative Technique – applicant types the EXACT contents of the Operative Record, but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view) The type of anesthesia used and duration of surgery must be stated. • Histopathology Report, if applicable - applicant types the EXACT contents of the histopathology report, with gross and microscopic descriptions but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view and stamped Certified True Copy by the Records Section) 	
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IMPORTANT: The original and previously submitted book-bound documents must be resubmitted for reference purposes.

All of the above requirements must be submitted book-bound with soft cover (total of two identical book-bound copies, one for the PBOG and one receiving copy of the applicant).

Use A4-size paper with 2-inch margin on the left or the binding side.