Part I Written Examination Sequence of Requirements of First Time Application

CHECKLIST		
Cover page – TITLE: "Requirements for Diplomate Part I" (New Application) 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.		
Application Form	Completely filled out (with most recent photo, and signed by (a) Applicant, (b) Department Chair, (c) Regional Director EXCEPT NCR Regional Director, and (d) three active POGS Fellows endorsing the applicant)	
Certificates	Jurat Notarization (this is a **CORE** requirement)	
	Photocopy of Certificate of Completion (for graduates of DOH Training Hospitals) or Diploma of Residency Training from the hospital	
	Certificate of Good Standing from PMA or its component society	
	Photocopy of updated valid PRC ID (at the time of application)	
	Photocopy of PBOG Certificate/s of Accreditation for Residency Training Program during the applicant's period of training (A resident should have completed four (4) years in an accredited training program. For newly accredited training programs and training programs that have been revoked/suspended, a resident should have	

	completed at least two (2) years under an accredited program prior to graduation.)	
	Certification from the Department Chair AND the Hospital/Medical Director, attesting to the authenticity of the cases/procedures submitted (that the cases/procedures were admitted and performed by applicant)	
	Certificate from attending physician/s of the cases submitted under Transfer of Technical Responsibility (TTR) or Private Case (PC)	
	CREED Certification of Eligibility (at least three RISE/in-service exams taken, with at least one taken on the 3rd or 4th year)	
	Institutional Data Privacy Policy	
	Certification from the Department Chair of one (1) Interesting Case Report and one (1) Research Paper done by the applicant during residency training (Title of paper and Date of accomplishment of each specified) and a copy of the Abstracts.	

Obstetric Cases (OB)	**Twenty-five (25) Obstetric Cases**, consisting of:
	• Primary Low Segment Cesarean Section
	  o Dystocia/Abnormal labor pattern – 2
	  o Non-reassuring fetal status – 2
	  o Placental abnormalities – 2
	  o Fetal malpresentation (breech/transverse, others) – 3
	  o Other indications (Medical/obstetrical/others) - 3
	• Classical Cesarean Section – 1
	• Repeat Low Segment Cesarean Section – 2
	• Indicated Cesarean Hysterectomy/Peripartum Hysterectomy/Hysterectomy with Mole-in-situ – 1 *	

	• Tubal Surgery for Ectopic Pregnancy – 3
	• Operative Obstetrics – 6
	  o Outlet or low forceps or vacuum-assisted delivery (outlet forceps extraction) – 2 *
	  o VBAC with operative/assisted vaginal delivery – 1
	  o Suction curettage/Vaginal evacuation of H. Mole – 1 *
	  o Vaginal breech delivery (with live fetus weighing at least 1.5 kg) *
	  o Indicated Manual extraction of placenta - 1
	
	Correct number is a **CORE requirement**.
	Variety of cases and indications is a **CORE requirement**.
	Cases should be done within FIVE (5) years from time of application (cases done during deployment, Fellowship or as MO-4 in government service are accepted).
	Of the 25 cases, at least 8 should have been managed by the applicant as "primary surgeon" and only a maximum of 17 Transfer of Technical Responsibility (TTR) or Private Case (PC) is allowed.
	
	* Transfer of Technical Responsibility or Private Case (PC) is NOT allowed in the following cases outside of the pandemic:
	1. Cesarean Hysterectomy/Peripartum Hysterectomy/Hysterectomy with Mole-in-situ
	2. Outlet or low Forceps Extraction/Vacuum extraction
	3. Suction curettage/Vaginal Evacuation of H. Mole
	4. Vaginal breech delivery
	
	TABULATION OF CASES/PROCEDURES with seven columns (in ARIAL font 12 pt, landscape view)
	• Tally number, Patient's age and OB score, Date admitted, Date discharged, Hospital where procedure was done, Own or Private Case (PC)	

	• Admitting Diagnosis • Pre-operative Diagnosis • Management, Operation/Procedure done, Anesthesia done, Date done • Indication for Surgery/Procedures (INCLUDE additional 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 SUPPORTING DOCUMENTS – arranged following the sequence in "Tabulation of Cases/Procedures" and correctly labelled with the Tally Number stated in the tabulation (OB1, OB2, OB3 …) • 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 • Friedman's Curve or 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, Pathologist or Pathology Department) 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).	
	Seventeen (17) Gynecologic Cases, consisting of:	

Gynecologic Cases (GYN)	• Hysterectomies or Operations on the Uterus (10)
	  ○ Total abdominal hysterectomy with or without salpingectomy or salpingo-oophorectomy, with the following indications:
	  ➢ Myoma or Adenomyosis – 4
	  ➢ Ovarian New Growth (benign or malignant) – 3
	  ➢ Others - 1
	  ○ Abdominal myomectomy – 1 *
	  ○ Vaginal hysterectomy – 1 *
	• Adnexal Surgery (any combination of the procedures below) (7)
	  ○ Oophorocystectomy – at least 2
	  ○ Salpingo-oophorectomy OR Oophorectomy – at least 1
	  ○ Salpingectomy (NOT for ectopic pregnancy) - optional
	
	Correct number is a **CORE requirement**.
	Variety of cases and indications is a **CORE requirement**.
	Cases should be done within FIVE (5) years from submission (cases done during deployment, Fellowship or as MO-4 in government service are accepted).
	Of the 17 cases, at least 10 (60%) should have been managed by the applicant as "primary surgeon" and only a maximum of 7 (40%) Private Case (PC) is allowed.
	
	* Private Case (PC) is NOT allowed in the following cases outside of the pandemic:
	1. Abdominal Myomectomy
	2. Vaginal Hysterectomy
	
	TABULATION OF CASES/PROCEDURES with seven columns (in ARIAL font 12 pt, landscape view)	

	• Tally number, Patient's age and OB score, Date admitted, Date discharged, Hospital where procedure was done, Own or TTR • Admitting Diagnosis • Pre-operative Diagnosis • Management, Operation/Procedure done, Anesthesia done, Date done • Indication for Surgery/Procedures (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 SUPPORTING DOCUMENTS – arranged following the sequence in "Tabulation of Cases/Procedures" and correctly labelled with the Tally Number stated in the tabulation (GYN1, GYN2, GYN3 …) • 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 • 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, Pathologist or Pathology Department) • 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).	

Other Gynecologic (OTH) Cases	**Eight (8) Other Gynecologic Cases,** consisting of any combination of procedures below: • Diagnostic curettage or endometrial biopsy – max. 3 • Bartholin's cyst excision or marsupialization – max. 2 • Diagnostic hysteroscopic procedure – max. 2 • Biopsy of cervix, vagina or vulva – max. 2 • Excision of vaginal or vulvar lesion – max. 2 • Colporrhaphy – max. 2 • Interval bilateral tubal ligation/permanent sterilization – max. 2 • Excision/electrocautery of genital warts – max. 2 • Evacuation of vulvo-vaginal hematoma (with ligation of bleeders, non-puerperal) – max. 2 • Repair of genital tract lacerations (non-puerperal) – max. 2 • Endocervical polypectomy – max. 2 • Vaginal myomectomy – max. 2 • Hysterosalpingography – max. 2 • Hymenectomy/Hymenotomy – max. 1 Correct number is a **CORE requirement**. Variety of cases and indications is a **CORE requirement**. Cases should be done within FIVE (5) years from submission (cases done during deployment, Fellowship or as MO-4 in government service are accepted). Of the 8 cases, at least 5 (60%) should have been managed by the applicant as "primary surgeon" and only a maximum of 3 (40%) Private Case (PC) is allowed. TABULATION OF CASES/PROCEDURES with seven columns (in ARIAL font 12 pt, landscape view) • 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/Procedures (INCLUDE Justification if there is deviation from standard of care) • Final Diagnosis • Outcome/Histopathology result SUPPORTING DOCUMENTS – arranged following the sequence in "Tabulation of Cases/Procedures" and correctly labelled with the Tally Number stated in the tabulation (OTH1, OTH2, OTH3 …) • 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 • 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, Pathologist or Pathology Department) • 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).	
All of the above requirements must be submitted book-sound 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.		