|  |  |
| --- | --- |
| **Last Nam** |  |
| **First Name** |  |
| **Date of Birth** | DD.MM.YYYY | **Place of Birth** | City/Province |
| **Civil Status** | [ ]  Single [ ]  Married  | **Sex** | [ ]  Female [ ]  Male |
| **Children (ages)** |  |
| **Landline** |  | **Cellphone** |  |
| **Email Address** |  |
| **Skype ID** |  |
| **Home Address** |  |
| **Present Location** |  |

Paste photo here

(photo must be like the one on your ID or on your passport)

|  |
| --- |
| **PROFESSIONAL EXPERIENCE** |
| **POSITION: present or latest,** dd.mm.yyyy started – dd.mm.yyyy ended (xx years / xx months) |
| **EMPLOYER NAME:** |
| **LOCATION:** |
| **EMPLOYER DESCRIPTION**: (what kind of institution, hospital, clinic, nursing home, capacity, specialization… etc) |
| **DEPARTMENT**: f.ex ICU, xx years xx months |
| **DESCRIPTION OF TASKS & RESPONSIBILITIES**: |
| **-** what are/were you doing**-****-** |
| **CASES HANDLED:** |
| - what situation/condition you are/were handling/treating/involved with and the medical devices/machines used-**-** |
| **POSITION:** dd.mm.yyyy started – dd.mm.yyyy ended (xx years / xx months) |
| **EMPLOYER NAME**  |
| **LOCATION**  |
| **EMPLOYER DESCRIPTION**: (what kind of institution, hospital, clinic, nursing home, capacity, specialization… etc) |
| **DEPARTMENT**: f.ex ICU, xx years xx months |
| **DESCRIPTION OF TASKS & RESPONSIBILITIES**: |
| **-** state here each of your responsibilities and describe briefly what you are/were doing to fulfill such responsibility**-****-** |
| **CASES HANDLED:**  |
| - state here what situation/condition you handled/treated/involved with and the medical devices/machines used-- |
| **POSITION:** dd.mm.yyyy started – dd.mm.yyyy ended (xx years / xx months) |
| **EMPLOYER NAME:** |
| **LOCATION:** |
| **EMPLOYER DESCRIPTION**: (what kind of institution, hospital, clinic, nursing home, capacity, specialization… etc) |
| **DEPARTMENT**: f.ex ICU, xx years xx months |
| **DESCRIPTION OF TASKS & RESPONSIBILITIES**: |
| **-** state here each of your responsibilities and describe briefly what you are/were doing to fulfill such responsibility-- |
| **CASES HANDLED**: |
| - state here what situation/condition you handled/treated/involved with and the medical devices/machines used-- |
| **POSITION:** dd.mm.yyyy started – dd.mm.yyyy ended (xx years / xx months) |
| **EMPLOYER NAME:** |
| **LOCATION:** |
| **EMPLOYER DESCRIPTION**: (what kind of institution, hospital, clinic, nursing home, capacity, specialization… etc) |
| **DEPARTMENT**: f.ex ICU, xx years xx months |
| **DESCRIPTION OF TASKS & RESPONSIBILITIES**: |
| **-** state here each of your responsibilities and describe briefly what you are/were doing to fulfill such responsibility-- |
| **CASES HANDLED**: |
| - state here what situation/condition you handled/treated/involved with and the medical devices/machines used-- |
|  |
| **POSITION:** dd.mm.yyyy started – dd.mm.yyyy ended (xx years / xx months) |
| **EMPLOYER NAME:** |
| **LOCATION:** |
| **EMPLOYER DESCRIPTION**: (what kind of institution, hospital, clinic, nursing home, capacity, specialization… etc) |
| **DEPARTMENT**: f.ex ICU, xx years xx months |
| **DESCRIPTION OF TASKS & RESPONSIBILITIES**: |
| **-** state here each of your responsibilities and describe briefly what you are/were doing to fulfill such responsibility-- |
| **CASES HANDLED**: |
| - state here what situation/condition you handled/treated/involved with and the medical devices/machines used-- |
| **AREAS OF SPECIALIZATION / EXPERTISE** |
| **MANAGEMENT** |
| **--** |
| **TECHNICAL** |
| - (f.ex. medical/clinical devices, machines, equipment, tools)-  |
| **(MAY ADD MORE AREAS IF ANY)** |
| **-** |
| **EDUCATIONAL BACKGROUND** |
| **Bachelor of Science in Nursing,** mm.yyyy – mm.yyyy |
| Name of University: |
| Location: |
| **High School** (Secondary), mm.yyyy – mm.yyyy |
| Name of High School: |
| Location: |
| **TRAININGS & SEMINARS** |
| **Training Name/Title,** dd.mm.yy-dd.mm.yy |
| **Organizer:** |
| **Location:**  |
| **Description:**-state here a brief description/content of the training |
| **Training Name/title:** dd.mm.yyyy-dd.mm.yyyy |
| **Organizer:** |
| **Location:**  |
| **Description:****-** state here a brief description/content of the training-- |
| **Training Name/title:** dd.mm.yyyy-dd.mm.yyyy |
| **Organizer:** |
| **Location:** |
| **Description:****-** state here a brief description/content of the training**-****-** |
| **CREDENTIALS & CERTIFICATIONS** |
| **Philippine Nurse Licensure Examination**, month & year released - month & year expires (1st release: month / year) |
| -**f. ex.: Intravenous Therapy Nurse License**, valid until: month year |
| Name of Institution which conducted/released the certification |
| **Basic Life Support,** valid until: month year |
|  Name of Institution which conducted/released the certification |
| **Pediatric Pulmonary Care**, valid until: month year |
|  Name of Institution which conducted/released the certification |
| **advanced Cardiovascular Life Support** |
| Name of Institution which conducted/released the certification |
| **-etc** |
|  |
| **LANGUAGE SKILLS** |
| English: [ ] Basic Level [ ] Business Level [ ] Good [ ] Very Good [ ] Excellent |
| Pilipino: mother tongue |
| German: [ ] A1 [ ] A2 [ ] B1 [ ] B2 [ ] C1 [ ]  going on [ ] none [ ] certified  |
| other Languages: [ ] Basic Level [ ] Business Level - [ ] Good [ ] Very Good [ ] Excellent |
| **HOBBIES** |
| **-** |
| **-** |
| **-** |
| **-** |
| **EMPLOYMENT PREFERENCE** |
| Set-up: [ ]  Hospital [ ]  Senior/Nursing Home [ ]  Rehabilitation Clinic [ ]  Out Patient [ ]  No Preference |
| Department:  |
| Location: [ ]  Big City [ ]  Medium/Small City [ ]  Province [ ]  Village [ ]  No Preference |
| **DRIVING LICENSE** |
| Philippine driving licence, category - expiry date: month year |
| **CONTACT PERSON/S IN CASE OF EMERGENCY** |
| Name: |  |  |
| Relationship: |  |  |
| Address: |  |  |
| Tel. Nos.: |  |  |
| Email:  |
| DSCS/mb\_24072018 |

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