Annex B.1 Health Human Resource Survey Toolfor PhilHealth Konsulta Provider

Name of facility: _____ Date of Assessment: (MM/DD/YY)_____
Address: _____

A. Physician: Total Number: ____ Total Number of Hours per Week: _____

Name	PhilHealth Member (Y/N)	Accreditation Number	Accreditation validity	PRC Lic #	Date of Expiry	Total Number of Hours per Week

B. Nurse Total Number: ____

Name	PhilHealth Member (Y/N)	License Number	Date of Expiry

C. Midwife Total Number: ____

Name	PhilHealth Member (Y/N)	License Number	Date of Expiry

Prepared by: _____ Attested correct by: _____

_____ _____

(Designation) Head of Facility/ Medical Director/ Chief of Hospital
(Signature over printed name and date signed)