**RESUME FOR OUR LADY OF LOURDES NURSING APPLICANTS**

**PERSONAL INFORMATION**

Name :

Current Address :

Mobile Number :

E-mail Address :

Skype ID :

Age :

Date of Birth :

Civil Status :

Gender :

**EDUCATION**

**MASTER’S**

Degree :

University :

Full Address :

Period Attended :

Date of Graduation :

**COLLEGE**

Diploma :

University :

Full Address :

Period Attended :

Date of Graduation :

Honor :

Diploma :

University :

Full Address :

Period Attended :

Date of Graduation :

Honor :

**SECONDARY**

School

Full Address :

Period Attended :

School

Full Address :

Period Attended :

School

Full Address :

Period Attended :

**ELEMENTARY**

School :

Full Address :

Period Attended :

School :

Full Address :

Period Attended :

School :

Full Address :

Period Attended :

**LICENSING/CERTIFICATION**

**Philippine Nursing License**

PRC ID No.:

Date of Issue of first PRC license - Day/Month/Year:

Date of Expiration of current PRC license – Day/Month/Year:

**Other Licenses**

Title:

License No.:

Date of Issue:

Date of Expiration:

Title:

License No.:

Date of Issue:

Date of Expiration:

Title:

License No.:

Date of Issue:

Date of Expiration

**ORGANIZATIONAL AFFILIATIONS**

Name:

Name:

Name:

**IELTS SUMMARY**

Type of Test:

Date of Test:

Overall Test Score:

Listening Score:

Reading Score:

Writing Score:

Speaking Score:

**NMBI STATUS**

Awaiting Decision Letter: Date payment made to the NMBI:

Holding Decision Letter: Date Decision Letter issued:

**HISTORY FROM THE PRESENT DATE DOWN TO THE DATE OF GRADUATION**

Name of Hospital:

Full Address:

Brief Description of Hospital:

**CASES HANDLED – ONE SUMMARY FROM ALL EMPLOYMENT EXPERIENCES**

**EQUIPMENT HANDLED - ONE SUMMARY FROM ALL EMPLOYMENT EXPERIENCES**

**TRAINING/SEMINARS**

Title:

Date:

Title:

Date:

Title:

Date:

**PROFESSIONAL REFERENCES**

Name:

Title:

Name of Hospital:

Landline No.:

Mobile No.:

E-mail Address:

Name:

Title:

Name of Hospital:

Landline No.:

Mobile No.:

E-mail Address:

Name:

Title:

Name of Hospital:

Landline No.:

Mobile No.:

E-mail Address:

 **VERIFICATION OF SERVICE ‘VOS’ CONTACTS**

Name:

Title:

Name of Hospital:

Landline No.:

Mobile No.:

E-mail Address:

Name:

Title:

Name of Hospital:

Landline No.:

Mobile No.:

E-mail address: