|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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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