Philippine Board of Pain Medicine
PAIN MEDICINE TRAINING UNIT DATASHEET

Name of Pain Unit: _____
Address of Pain Unit: _____
Pain unit phone no.: _____ Email address: _____
Pain unit website: _____ Year unit was established: _____

APPLICATION FOR:

_____ **Accreditation and classification of pain management unit**
____ New/ first-time application ____ Renewal ____ Revisit ____ Re-accreditation

_____ **Accreditation as Pain Medicine fellowship training unit**
____ New/ first-time application ____ Renewal ____ Revisit ____ Re-accreditation

If applicable: Year pain unit was first accredited _____ Year last accredited _____

Name of Head of Pain Unit: _____
Email address: _____
Mobile phone no.: _____

Bed capacity of the hospital: _____
Does the Pain Unit have access to inpatient beds? YES / NO
On the average over the last four years, how many NEW cases were referred per year with:

Pain Type	2018	2019	2020	2021
Acute pain				
Chronic Non-cancer pain				
Cancer pain				
Palliative/ Hospice care				
TOTAL				

TRAINING STAFF:

Name of Medical Staff (First, M.I., Last)	Specialty, Year certified	DPBPM – Year certified	PSP Member*	IASP Member*	GCP Cert – year *
Head:					
Fellowship Training Officer:					
Staff:					
1.					
2.					
3.					

*Must present certification of current/ updated membership or completion of course

NURSING AND ALLIED HEALTH STAFF

Name of Non-Medical Staff (First, M.I., Last)	Discipline	Year Board-certified	PSP Member*	IASP Member*
Head:				
Asst. Head:				
Staff:				
1.				
2.				
3.				

CURRENT FELLOW TRAINEES

Name of Pain Fellow Trainees (First, M.I., Last)	Discipline/ Specialty	Year Board-certified	PSP Member	IASP Member	GCP Cert – year
Chief Fellow:					
Pain Fellows:					
1.					
2.					
3.					

DECLARATION

I certify that the information given in this document is correct and may be considered by the Philippine Board of Pain Medicine in respect of this pain unit's application for accreditation:

____ Pain Management unit

____ Pain Medicine fellowship training program.

Unit Head/ Director: _____ Date signed: _____

Signature over Printed Name

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Please submit the following documents with the datasheet**:

1. Staff rosters including daily schedules and on-call rosters
2. Unit continuing medical education / professional development programs
3. Unit quality assurance programs
4. Research output of Unit staff
5. Formal teaching and tutorial programs
6. Schedule of assessments performed in the past 12 months

** Items # 4 to 6 - applicable when applying for accreditation of Pain Medicine training program