NATIONAL CENTER FOR MENTAL HEALTH HUMAN RESOURCE MANAGEMENT OFFICE **PERMISSION TO ENGAGE IN LIMITED PRIVATE PRACTICE OF PROFESSION**	*HRMO PELPPP Rev. 2 12 Sep 2024*

Please write legibly or in PRINT, and put a check mark on the appropriate boxes.

(LAST NAME)	(FIRST NAME)	(MIDDLE INITIAL)

Position			
Service	☐Medical ☐Ancillary ☐Nursing ☐Finance ☐HOPSS		
Employment	☐Permanent ☐Temporary ☐Others: ____________________		
Address			
Contact No.		Email Address	

LIMITED PRIVATE PRACTICE OF PROFESSION			
1. Nature of proposed practice of position			
☐ Professional Practice, please specify: ____________________ ☐ Commissioned Work ☐ Technical Assistance ☐ Policy Analysis ☐ Teaching / Training ☐ Program / Project Evaluation ☐ Research ☐ Others, please specify: ____________________			
2. Place of practice of profession			
If it involves a contract, please indicate the organization/agency, and its business address			
3. Time Shift		Time Schedule of Limited Private Practice of Profession	
Day-off			
4. Last two (2) Performance Commitment and Review Ratings			
Rating period:	Rating:	Rating period:	Rating:

I hereby abide by the rules and regulations governing limited practice of profession, such as

☐ **Working outside of regular office hours and/or using authorized leave credits**

☐ **Not involving the use of government resources**

☐ **Provided that such activities do not conflict with or interfere with my duties and responsibilities as an employee of this specialty center.**

SIGNATURE OVER PRINTED FULL NAME

Date:

(See back page)

1st Endorsement
RECOMMENDATION

Respectfully forwarded to Human Resource Management Office inviting attention to the basic communication and* ____
____.

____
(SIGNATURE OVER PRINTED NAME)
Highest Ranking Supervisor
Date:

*Indicate additional task for the HRMO in relation to the Application, such as very stated information, working schedule, etc.

2nd Endorsement
VERIFICATION OF INFORMATION

Respectfully forwarded to the Medical Center Chief** ______________________________
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____
(SIGNATURE OVER PRINTED NAME)
Chief, Human Resource Management Office
Date:

**Indicate your findings in relation to the additional Task directed by the signatory above.

In the exigency of service or when public interest so requires, this authority may be revoked anytime.

APPROVED:

____
NOEL V. REYES, MD. FPPA, MMHoA
Medical Center Chief II
Date: ____________