Republic of the Philippines
DEPARTMENT OF HEALTH

HEALTH FACILITIES AND SERVICES REGULATORY BUREAU

ORDER OF PAYMENT

Date: ______________________

NAME : ____

ADDRESS : ____

To CASHIER:

Please charge the amount of ____ Php _____________ for:

( ) Written Examination fee
( ) Oral/Practical Examination fee
( ) Others. Please specify ______________________________

Prepared by:

____
Licensing Officer/Designate Staff

Received the above payment/s:
Name/Signature: ________________________
Amount: _______________
Cash/PMO/Check. No. ______ Date:_________
O.R. No. Issued ________________ Date:_________

Form OP09(CEMT CEUE)
Revision:00
4/3/2019

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