

Iploy Staffing Solutions

9th Floor , Ayala Center Cebu Tower (ACCT) Bohol St. Cebu Business Park, Cebu City, Philippines

Anthony Sanchez Gulpan

Dear HR MANAGEMENT,

I am writing this letter to inform my intent of resignation effective 7/9/2024. I am no longer capable of fulfilling my duties and responsibility in my position. This, and all several other reasons, First, is my dissatisfaction towards the management, with the exception of my team leader. In all the years that I have worked I am have not felt appreciated and protected as an employee. First, is how your QA process is not calibrated affecting our work and how we handle our patients, in effect, we the agents get the mark down which is unjustifiable. In addition to, the lack of engagement, this keeps our morale up and make us feel appreciated and if there are event it felt like it was just with bare minimum efforts. Also, how I felt when upper management held my team leader accountable for the high attrition of newbies it impacts me because I am the teams POC and assisted my tl with training the newbies even if it is outside of my scope as a POC and even if they are still under the training team. This continuous struggle between management and my team lead affects us, his members and me the POC. I also want to raise the lack of effort of my other co POC as I have went above and beyond in assisting and helping even their agents but could not do the same to my team that I am handling. The lack of effort as well on floorwalking and assisting and in the end their agent go to me for assistance adding up to my work load. This affected my mental and physical health due to stress. Thus, I have ultimately decided to take a rest and will plan to pursue and finish my studies since my sibling already graduated.

I send my sincerest appreciation to your company for my 3 years of working with you as you are are my first BPO though I wish for you to listen to the needs of your agents since we are the bread and butter of the company. I appreciate my TL for being very patient as well and for being a really good mentor I wish you more blessing and tin you future endeavor.

Thank you and have a nice day!

Yours Truly,


Anthony Sanchez Gulpan

Cebu City

Age 21

Sex W

Weight (kg) 60 kg

Patient's Contact Nos.



VICENTE SOTTO MEMORIAL MEDICAL CENTER
B. Rodriguez St., Cebu City

PRESCRIPTION

FUNDING

Full Name : Emparan, Anthony S.

1/11/2021

Ward / Unit : _____ Age & Sex : 21/M

Date :

Tag # : _____ Charge # : _____

Full Name :

Rx

Ward / Unit :

Tag # :

Rx

#90

Vit. B complex tablet

Sig. take 1 tablet once a day

Anro M. Begonies, MD
Family & Community Medicine
Lic. No. 018817

M.D.

[doctor's tru-dat bearing full name, license # & S2 license #)

Issued By : _____

Received By : _____

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VSMC-MSD-PHARMA-F-15 Rev. 3

June 15, 2018

June 15, 2018

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VICENTE SOTTO MEMORIAL MEDICAL CENTER
B. Rodriguez St., Cebu City

PRESCRIPTION

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Other (+) (-)

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Full Name : Gulpan, Anthony **FUNDING**
Ward / Unit : _____ Age & Sex : 21/M Date : 1/11/2021
Tag # : _____ Charge # : _____

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1/2 glass of water

Anro M. Degantes, MD
Family & Community Medicine
Lic. No. 0000000000

M.D.

[Doctor's stamp bearing full name, license # & S2 license #)

Issued By : _____

Received By : _____

No.

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MED-F-30 F
per 30, 201

NTP REFERRAL FROM HOSPITALS

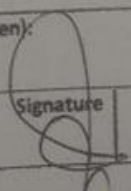
TB CASE NUMBER					

To: LAC

Date Referred: Jan. 11, 2021

Please accommodate the patient bearing this referral form. Please inform the Referring DOTS Staff as soon as patient has resumed/started treatment and registered by calling, sending SMS /e-mail or sending back the Return Slip below.

(To be accomplished by Referring DOTS Facility)

Name of Referring Hospital <u>VSMHC</u>	Telephone No.	Fax Number	E-mail address
Full Address of Referring Hospital <u>B. Rodriguez St. Cebu City</u>			
Name of Patient <u>Gulpan, Anthony</u>	Age <u>21</u>	Sex <u>M</u>	Weight (kg) <u>60kgs</u>
Patient's Previous Address (if trans-out)		Patient's Contact Nos. <u>095158 78943</u>	
Patient's Current Address <u>Purok 3 Upper Kamputhaw, Cebu City</u>		Date treatment Started: ____/____/____ (mm/ dd/ yyyy)	
Reason for referral <input type="checkbox"/> For DSSM <input type="checkbox"/> For isoniazid preventive therapy (IPT) (children 0-4 yrs. Old) <input checked="" type="checkbox"/> For registration and treatment <input type="checkbox"/> For Trans-out <input type="checkbox"/> Others, specify _____ (Note: if patient is less than 10 yrs old, attach the NTP Diagnosis Form for Children 0-5 yrs. Old)			
Classification of Patient <input checked="" type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-pulmonary Site _____ <input type="checkbox"/> RAD <input type="checkbox"/> Other (+) (-)	Type of Patient <input checked="" type="checkbox"/> New <input type="checkbox"/> Relapse <input type="checkbox"/> Failure <input type="checkbox"/> Transfer-in <input type="checkbox"/> Other (+) (-)	Category of Treatment <input checked="" type="checkbox"/> Category I <input type="checkbox"/> Category II <input type="checkbox"/> Category III <input type="checkbox"/> Category IV (MDR-TB)	
Remarks (e.g. indicate duration and treatment given):			
Printed Name Referring DOTS Staff <u>ARNO M. B. Bentes, MD</u> Family & Community Medicine LIC. No. 01-9017	Signature 	Cellphone number	Designation <u>MO3</u>

