SSGMC
SOUTH SUDAN
GENERAL MEDICAL
COUNCIL

FORM 1A

APPLICATION FOR PRELIMINARY REGISTRATION AS A DENTIST/ MEDICAL DOCTOR/ PHARMACIST

(INTERNSHIP LICENSE)

PHOTO

YEAR _____

Surname: _____

First Name: _____ Other Names: _____

Gender: Male ☐ Female ☐

Date of Birth: _____ Nationality: _____

National ID No: _____ Issuing Date: _____

Physical Address: _____

State: _____ County: _____ Town: _____

Phone No: _____ Email: _____

Academic Qualifications:

Degree/ Certificate Held: _____

Date Qualified: _____ Country: _____

School/College: _____

University/ Institute: _____

Physical Address: _____ Website: _____

Contact Phone: _____ Email: _____

Name of Internship Training Facility: _____

Tel No: _____ E-mail Address: _____

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Requirements

(i) Copy of National ID/Passport
(ii) Two (2) colored passport sized photo with Name and ID number indicated at the back.
(iii) Certified copies of professional, academic certificates and Academic Transcripts.
(iv) All Academic/ Professional and transcript certificates have to be authenticated from the relevant specialized authority. Any certificate in a language other than English will have to be accompanied with a translated version.
(v) Evidence of completing Medical/Pharmacist or Dental training in an accredited University (Locally or regionally) The institution must appear in the list submitted by deans of Accredited National Medical/Dental Schools or other relevant and accredited institutions. If regional institution must have reciprocal recognition.
(vi) Application & Registration fees (See the attached fees structure)
*(vii) All payments are **non-refundable** and should be made at the given **Bank details**. The original banking slip must be submitted together with the form.*

(COOPERATIVE BANK OF SOUTH SUDAN, JUBA BRANCH, AC NAME: SOUTH SUDAN GENERAL MEDICCAL COUNCIL, AC#: 01126004358500)

Declaration:

I hereby certify that the above information is correct to the best of my knowledge and that I have met the above requirements.

Signature of applicant: _____ *Date:* _____

For Official Use:

Verified by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Recommended by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Approved ☐ **Not Approved** ☐

Name: _____ Designation: _____

Signature: _____ Date: _____