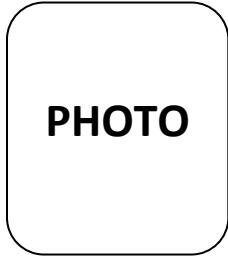




FORM 2A

**APPLICATION FOR PERMANENT REGISTRATION AS A DENTIST/
MEDICAL DOCTOR**

YEAR _____



Personal Information:

Surname: _____

First Name: _____ Other Name: _____

Gender: Male Female

Date of Birth: _____ Nationality: _____

National ID No: _____ Issuing Date: _____

Physical Address: _____

State: _____ County: _____ Town/City: _____

Phone No: _____ Email: _____

Academic Qualification:

Degree/ Certificate Held: _____

Date Qualified: _____ No. of Years Training undertaken: _____

School/College: _____

University/ Institute: _____

Contact details: _____

Website: _____

Contact Phone: _____ Email: _____

Name of Internship Training Facility: _____

Tel No: _____ E-mail Address: _____



S/No.	Training Facility	Tel No	E-mail Address	Period of Internship
1.				From: To:
2.				From: To:
3.				From: To:
4.				From: To:
5.				From: To:
6.				From: To:

Particulars and testimonials covering the period(s) of experience. Please list and provide/attach all supporting evidence. Only certified true copies must be provided/attached:

Name of the Employer: _____

Address: _____ Town: _____

County: _____ State: _____

Tel No: _____ E-mail: _____

Requirements

- (i) Copy of National ID/Passport
- (ii) Four (4) 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.
- (v) Any certificate in a language other than English will have to be accompanied with a translated version.
- (vi) Evidence of completion of the internship.
- (vii) 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.
- (viii) Evidence of registration from partner States' Medical Boards and Councils (for those with foreign qualifications and internship training).
- (ix) All credentials from foreign countries must be verified by any of the council's recognized international verification agency (EPIC, Dataflow, etc.).
- (x) Application & Registration fees (see the attached fees structure)
- (xi) 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 MEDICAL COUNCIL, AC#: 01126004358500 - SSP)**

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: _____