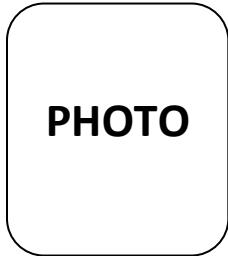




FORM 3B

**APPLICATION FOR PRELIMINARY REGISTRATION FOR FOREIGN
MEDICAL DOCTORS/ DENTISTS/ PHARMACISTS
(INTERNSHIP LICENSE)**



YEAR _____

PHOTO

Personal Information:

Surname: _____

First Name: _____ Other Name: _____

Gender: Male Female

Date of Birth: _____ Nationality: _____

Passport No: _____ Issuing Date: _____

Address: _____

Code: _____ Town: _____ Country: _____

Phone No: _____ Mobile: _____

Email: _____

Academic Qualification:

Degree/ Certificate/ License Held: _____

Date Qualified: _____ Country: _____

School/College: _____

University/ Institute: _____

Contact details: _____

Website: _____

Contact Phone: _____ Email: _____

Particulars of Experience (e.g. posts held, type of practice in which the application has been engaged): _____

Countries in which the applicant has practiced: _____

Testimonials covering the period(s) of experience: _____

The Employer: _____

Tel No: _____ E-mail Address: _____

Mandatory Requirements

- (i) *Copy of Refugee ID/Passport*
- (ii) *Two (2) Colored pass port size photo*
- (iii) *Certified copies of professional and Academic certificates*
- (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) *Curriculum Vitae*
- (vi) *Evidence of appropriate linguistic skills in English.*
- (vii) *Authentication by Minister of Higher Education Science and Technology (MoHEST) confirming recognition of the medical/dental school (if foreign trained)*
- (viii) *Application & Registration fee (see the attached fees structure).*
- (ix) *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#: SSP 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:

(This process must take a max of 2 weeks)

Verified by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Recommended by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Approved

Not Approved

Specialty/ Sub-specialty: _____

Name: _____ Designation: _____

Signature: _____ Date: _____