SSGMC
SOUTH SUDAN GENERAL MEDICAL COUNCIL

FORM 3B

APPLICATION FOR PRELIMINARY REGISTRATION FOR FOREIGN MEDICAL DOCTORS/ DENTISTS/ PHARMACISTS

(INTERNSHIP LICENSE)

PHOTO

YEAR _____

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: _____

SSGMC
SOUTH SUDAN
GENERAL MEDICAL
COUNCIL

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 MEDICCAL 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:* _____

SSGMC
SOUTH SUDAN
GENERAL MEDICAL
COUNCIL

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: _____