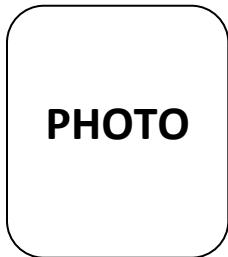

APPLICATION FOR PRELIMINARY REGISTRATION AS A SPECIALIST



YEAR _____

PHOTO

PERSONAL INFORMATION:

Surname: _____

First Name: _____ Other Name: _____

Date of Birth: _____ Nationality: _____

National ID No: _____ Gender: Male Female

Permanent Reg. No: _____

Physical Address: _____

State: _____ County: _____ Town: _____

Phone No: _____ Email: _____

ACADEMIC QUALIFICATION:

Specialty/Degree/Certificate Held: _____

Date Qualified: _____ Country: _____

School/College: _____

University/ Institute: _____

Contact details: _____

Website: _____

Contact Phone: _____ Email: _____

The Employer: _____

Tel No: _____ E-mail Address: _____

SPECIALTY TRAINING DETAILS:

Specialty for which Preliminary Registration is Sought:

Name of Accredited Training Institution/Hospital: _____

Address of Training Institution: _____

Training Program Director/Supervisor: _____

Contact Phone: _____ Email: _____

Official Start Date of Specialist Training (DD/MM/YYYY): _____

Anticipated End Date of Training (DD/MM/YYYY): _____

Is this a recognized/accredited postgraduate training program? [] Yes [] No

If yes, name the accrediting body (National/International Body):

Requirements

- (i) Copies of Primary Medical Degree Certificate and Transcript
- (ii) Copy of Permanent Registration Certificate
- (iii) Copy of post graduate qualification and official transcript.
- (iv) Valid Practicing License from country of origin/last practice
- (v) Certificate of Good Standing/Professional Status from ALL previous registration authorities (Issued within last 3-12 months)
- (vi) Proof of Specialist Training Enrollment/Contract (Letter from Head of Institution) Must be on official letterhead
- (vii) All credentials from foreign countries must be verified by any of the council's recognized international verification agency (EPIC, Dataflow, etc.)
- (viii) Curriculum Vitae (Detailed, including all work experience)
- (ix) Four Passport-sized Photographs
- (x) Copy of the National ID
- (xi) Application & Registration fees (see the attached fees structure)

(xii) 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 – USD 02126004358500)

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: _____

Approval for Preliminary Registration:

Approved

Not Approved

Specialty: _____ Reg. No: _____

Name: _____ Designation: _____

Signature: _____ Date: _____

To be completed by the HEAD OF THE TRAINING INSTITUTION / PROGRAM DIRECTOR

This is to certify that:

Dr. _____ has been accepted into the accredited

(Name of Specialty)

training program at _____.

(Name of Institution)

The program runs from _____ / _____ / _____ to _____ / _____ / _____.

Dr. _____ will be under continuous supervision during this training period.

We endorse their application for Preliminary Specialist Registration with the SSGMC.

Name of Head/ Director (Printed): _____

Title/Position: _____

Signature: _____ Date (DD/MM/YYYY): _____

(Official Stamp/Seal of the Institution)