SSGMC
SOUTH SUDAN GENERAL MEDICAL COUNCIL

FORM 4

APPLICATION FOR PRELIMINARY REGISTRATION AS A SPECIALIST

PHOTO

YEAR _____

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: _____

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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)

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(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 MEDICCAL 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: _____

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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)