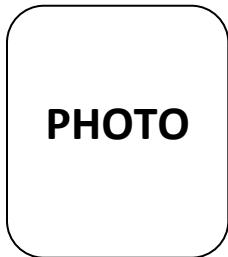


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## **APPLICATION FOR PERMANENT REGISTRATION AS A SPECIALIST**



YEAR \_\_\_\_\_

**PHOTO**

### **Personal Information:**

Surname: \_\_\_\_\_

First Name: \_\_\_\_\_ Other Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male  Female

National ID No: \_\_\_\_\_ Permanent Reg. No: \_\_\_\_\_

Physical Address: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_ Town: \_\_\_\_\_

Phone No: \_\_\_\_\_ Email: \_\_\_\_\_

### **Academic Qualification:**

Degree/ Diploma/ Certificate Held: \_\_\_\_\_

Date Qualified: \_\_\_\_\_ Country: \_\_\_\_\_

School/College: \_\_\_\_\_

University/ Institute: \_\_\_\_\_

Contact details: \_\_\_\_\_

Website: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

The Employer: \_\_\_\_\_

Tel No: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Specialty/ Sub-specialty applied for: \_\_\_\_\_

Post-graduate qualifications: \_\_\_\_\_

Institution: \_\_\_\_\_

Date qualified: \_\_\_\_\_ Country: \_\_\_\_\_

*Number of years of experience in specialty/ sub-specialty after obtaining postgraduate qualifications (indicate the number of years or months, name of institution(s) attended, and name of two supervisors whose address must accompany this application)*

No. of years/months: \_\_\_\_\_ Institution: \_\_\_\_\_

**Name of the Supervisor (1):** \_\_\_\_\_

P.O. Box: \_\_\_\_\_ Code: \_\_\_\_\_

Town: \_\_\_\_\_ Country: \_\_\_\_\_

Tel No: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Name of the Supervisor (2):** \_\_\_\_\_

P.O. Box: \_\_\_\_\_ Code: \_\_\_\_\_

Town: \_\_\_\_\_ Country: \_\_\_\_\_

Tel No: \_\_\_\_\_ E-mail: \_\_\_\_\_

## Requirements

- (i) Copy of post graduate qualification and other official transcripts.
- (ii) Evidence of completion of a minimum of 3-year rotation in a recognized training institution for Specialist recognition (as evidenced by a specialist postgraduate certification, MMeds, Fellowships, Board certifications and clinical MDs by post-graduate boards) At least One year (12 months) of a clinical rotation after 2 years post-basic specialist training period in a recognized institution for sub-specialist recognition as evidenced by certifications of trainers of the subspecialty applied for.
- (iii) Supportive recommendations from two (2) referees in the relevant field.
- (iv) Specialty and sub specialty must be in the approved fields.
- (v) All credentials from foreign countries must be verified by any of the council's recognized international

verification agency (EPIC, Dataflow, etc.).

(vi) Application & Registration fees (see the attached fees structure)

(vii) 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: \_\_\_\_\_

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**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: \_\_\_\_\_