SSGMC
SOUTH SUDAN GENERAL MEDICAL COUNCIL

FORM 5

APPLICATION FOR PERMANENT REGISTRATION AS A SPECIALIST

PHOTO

YEAR _____

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: _____

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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 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:* _____

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: _____