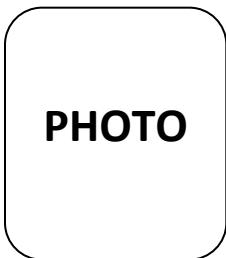


FORM 6

APPLICATION FOR PRIVATE PRACTICE LICENSE



YEAR _____

PHOTO

Personal Information:

Surname: _____

First Name: _____ Other Name: _____

Date of Birth: _____ Nationality: _____

National ID No: _____ Gender: _____ Male Female

SSGMC Reg. No: _____

Address: _____

Code: _____ Town: _____ Country: _____

Phone No: _____ Mobile: _____

Email: _____

Qualifications:

Dentist Medical Doctor Pharmacist

Particulars of Experience (e.g. posts held, type of practice in which the application has been engaged): _____

Name of authorized premises: _____

Tel No: _____ E-mail Address: _____



Notification for any changes of name, address and/or authorized premises: _____

Do you propose to practice on your own or to be employed full-time or part-time by a Private Practitioner? (give details)

What type of practice do you propose to engage in?

General Practitioner:

Specialist:

Specify the discipline (if specialist): _____

New License

Renewal

License No: _____

Duration: from _____ to _____

Mandatory Requirements

- (i) Copies of National ID/ Passport, Permanent Registration
- (ii) Appointment letter/ Contract or letter of no objection from the employer, schedule of duties should be provided for part-time practice.
- (iii) In case of New Premises, Inspection Report should be attached.
- (iv) Application & License fees (see the attached fees structure).
- (v) 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: _____

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: _____