SSGMC
SOUTH SUDAN
GENERAL MEDICAL
COUNCIL

FORM 6

APPLICATION FOR PRIVATE PRACTICE LICENSE

PHOTO

YEAR _____

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: _____

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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 purpose 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 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:* _____

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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: _____