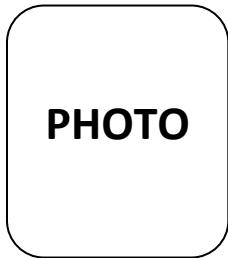

**APPLICATION FOR PROVISIONAL LICENSE FOR FOREIGN
DOCTORS/ SPECIALISTS**



YEAR _____

PHOTO

Personal Information:

Surname: _____

First Name: _____ Other Name: _____

Date of Birth: _____ Nationality: _____

Passport No: _____ Gender: _____ Male Female

SSGMC Reg. No: _____

Address: _____

Code: _____ Town: _____ Country: _____

Phone No: _____ Mobile: _____

Email: _____

Academic Qualification:

Degree/ Diploma/ License Held: _____

Date Qualified: _____ Country: _____

School/College: _____

University/ Institute: _____

Contact details: _____



Website: _____

Contact Phone: _____ Email: _____

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

Countries in which the applicant has practiced: _____

Testimonials covering the period(s) of experience: _____

The Employer: _____

Tel No: _____ E-mail Address: _____

New License Renewal License No: _____

Duration: from _____ to _____

Mandatory Requirements

- (i) *Copy of a valid Passport*
- (ii) *Current colored passport size photos*
- (iii) *Certified copies of professional certificates and transcripts (provide official translation if not in English)*
- (iv) *Introduction letter/job offer from the institution*
- (v) *Copy of SSGMC provisional registration certificate*
- (vi) *Copy of current/last practice license (if renewal)*
- (vii) *Copy of current CV (Resume)*
- (viii) *Copy of a valid work permit*
- (ix) *Application and License fees (see the attached fees structure)*
- (x) *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 –

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:

(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: _____