SSGMC
SOUTH SUDAN
GENERAL MEDICAL
COUNCIL

FORM 7

APPLICATION FOR PROVISIONAL LICENSE FOR FOREIGN DOCTORS/ SPECIALISTS

PHOTO

YEAR _____

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: _____

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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 MEDICCAL COUNCIL, AC#: SSP 01126004358500 – USD 02126004358500)

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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: _____