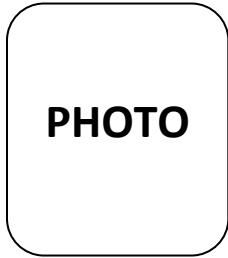


FORM 8

**APPLICATION FOR CERTIFICATE OF REGISTRATION STATUS
“CERTIFICATE OF GOOD STANDING”**



YEAR _____

PHOTO

Personal Information:

Surname: _____

First Name: _____ Other Name: _____

Date of Birth: _____ Nationality: _____

National ID No./ Passport No: _____ Exp. Date: _____

Gender: Male Female SSGMC Reg. No: _____

Physical Address: _____

State: _____ County: _____ Town: _____

Phone No: _____ Email: _____

Reasons for Certificate of Status: _____

Intended Country/ Country of stay/ Study/ Practice: _____

Institution: _____ Period: _____

If certificate is for travel, what is the expected return to the Country? _____

The Referee:

Dr./ Prof. (full name) _____

(indicate full names as they appear in the SSGMC Register)

Reg. No: _____ PO. Box: _____

Phone No: _____ Mobile No: _____

Email: _____

Being a practitioner of good standing, I do hereby declare that I have been and I am well acquainted with the said Dr. _____

Reg./ License No: _____ for the past _____ years, and further declare that during this time he/ she:

- (i) Has been engaged in Medical/ Dental/ Pharmacy Practice,
- (ii) Has conducted himself/herself well professionally and in a responsible manner,
- (iii) His/her character and conduct have been _____
- (iv) Reasons for certificate of status: _____

Signed _____ Date _____

Requirements:

- (i) A recommendation by a registered practitioner of good status (above mentioned referee)
- (ii) Attach a copy of current retention certificate/ private practice license/ temporary license for foreign practitioners.
- (iii) Two (2) colored passport size photos
- (iv) Copy of the Nationality ID/ Passport.
- (v) Evidence that the practitioner is not under any investigation by the SSGMC
- (vi) Application 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 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

Name: _____ Designation: _____

Signature: _____ Date: _____