SSGMC
SOUTH SUDAN
GENERAL MEDICAL
COUNCIL

FORM 8

APPLICATION FOR CERTIFICATE OF REGISTRATION STATUS "CERTIFICATE OF GOOD STANDING"

PHOTO

YEAR _____

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: _____

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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 MEDICCAL 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:* _____

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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** ☐

Name: _____ Designation: _____

Signature: _____ Date: _____