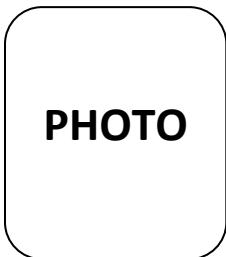

APPLICATION FOR PEER REVIEW



YEAR _____

PHOTO

Personal Information:

Surname: _____

First Name: _____ Other Name: _____

Date of Birth: _____ Nationality: _____

National ID No./ Passport No: _____ Gender: Male Female

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 (*please attach all the supporting evidence*):

Have any arrangements been made regarding employment? (*if so, give details*)

Mandatory Requirements

- (i) *Copy of National ID/Passport*
- (ii) *Colored passport sized photo*
- (iii) *Certified copies of professional and academic certificates*
- (iv) *(Copy of current CV*
- (v) *Evidence of postgraduate qualifications*
- (vi) *Certificate of status (good standing)*
- (vii) *Certificate of status from current regulatory authority*
- (viii) *Specialist recognition (if any) from current medical council*
- (ix) *Application fees.*
- (x) *Peer review / evaluation fees.*
- (xi) *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: _____