SSGMC
SOUTH SUDAN
GENERAL MEDICAL
COUNCIL

FORM 10

APPLICATION FOR PEER REVIEW

PHOTO

YEAR _____

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: _____

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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 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: _____