SSGMC
SOUTH SUDAN GENERAL MEDICAL COUNCIL

FORM 2A

APPLICATION FOR PERMANENT REGISTRATION AS A DENTIST/ MEDICAL DOCTOR

YEAR _____

PHOTO

1. Personal Information:

1.1. Surname: _____

1.2. First Name: _____ Other Names: _____

1.3. Gender: Male ☐ Female ☐

1.4. Date of Birth: _____ Nationality: _____

1.5. National ID No: _____ Issuing Date: _____

1.6. Physical Address: _____

1.7. State of origin: _____ County: _____ Town: _____

1.8. Phone No: _____ Email: _____

2. Academic Qualification:

2.1. Degree/ Certificate Held: _____

2.2. Date Qualified: _____ No. of Years Training undertaken: _____

2.3. School/College: _____

2.4. University/ Institute: _____

2.5. Contact details: _____

2.6. Website: _____

2.7. Contact Phone: _____ Email: _____

3. Internship Program:

3.1. Name of Internship Training Facility: _____

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3.2. Tel No: _____ E-mail Address: _____

3.3. Internship Training Details:

S/No.	Name of the Training Discipline	Training Facility	Period of Internship	Remarks
1.			From: To:	
2.			From: To:	
3.			From: To:	
4.			From: To:	
5.			From: To:	
6.			From: To:	

3.4. Particulars and testimonials covering the period(s) of experience. Please list and provide/ attach all supporting evidence. Only certified true copies must be provided/attached:

_____
_____
_____
_____
_____
_____

4. **Name of the Employer:** _____

4.1. Address: _____ Town:_____

4.2. County: _____ State: _____

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4.3. Tel No: _____ E-mail: _____

5. Requirements

(i) Copy of National ID/Passport
(ii) Four (4) colored passport sized photo with Name and Id number indicated at the back.
(iii) Certified copies of professional, academic certificates and Academic Transcripts.
(iv) All Academic/Proffesional and transcript certificates have to be authenticated from the relevant specialized authority.
(v) Any certificate in a language other than English will have to be accompanied with a translated version.
(vi) Evidence of completion of the internship.
(vii) Evidence of completing Medical/Pharmacist or Dental training in an accredited University (Locally or regionally) The institution must appear in the list submitted by deans of Accredited National Medical/Dental Schools or other relevant and accredited institutions. If regional institution must have reciprocal recognition.
(viii) Evidence of registration from partner States' Medical Boards and Councils (for those with foreign qualifications and internship training).
(ix) All credentials from foreign countries must be verified by any of the council's recognized international verification agency (EPIC, Dataflow, etc.).
(x) Application & Registration fees (see the attached fees structure)
*(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#: 01126004358500 - SSP)

6. 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:

Verified by:

Name: _____ Designation: _____

Signatur e: _____ Date: _____

Recommended by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Approved ☐ **Not Approved** ☐

Name: _____ Designation: _____

Signature: _____ Date: _____