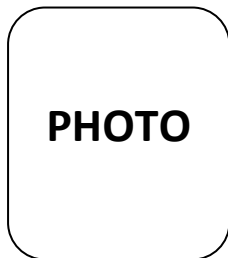


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**APPLICATION FOR PERMANENT REGISTRATION AS A DENTIST/  
MEDICAL DOCTOR**  
YEAR \_\_\_\_\_



**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: \_\_\_\_\_

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:

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4. Name of the Employer: \_\_\_\_\_

4.1. Address: \_\_\_\_\_ Town: \_\_\_\_\_

4.2. County: \_\_\_\_\_ State: \_\_\_\_\_

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/Professional 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 MEDICAL 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: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Recommended by:**

Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Approved**

**Not Approved**

Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_