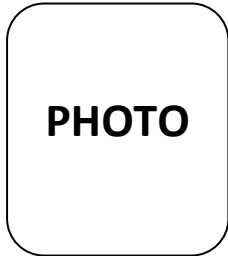

**APPLICATION FOR PRELIMINARY REGISTRATION FOR FOREIGN
MEDICAL DOCTORS/ DENTISTS/ PHARMACISTS
(INTERNSHIP LICENSE)**



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. Passport No: _____ Issuing Date: _____
- 1.6. Address: _____
- 1.7. Code: _____ Town: _____ Country: _____
- 1.8. Phone No: _____ Mobile: _____
- 1.9. Email: _____

2. Academic Qualification:

- 2.1. Degree/ Certificate/ License Held: _____
- 2.2. Date Qualified: _____ Country: _____
- 2.3. School/College: _____
- 2.4. University/ Institute: _____
- 2.5. Contact details: _____

2.6. Website: _____

2.7. Contact Phone: _____ Email: _____

2.8. Particulars of Experience (e.g. posts held, type of practice in which the application has been engaged): _____

2.9. Countries in which the applicant has practiced: _____

2.10. Testimonials covering the period(s) of experience: _____

3. The Employer: _____

Tel No: _____ E-mail Address: _____

4. Mandatory Requirements

- (i) *Copy of Refugee ID/Passport*
- (ii) *Two (2) Colored pass port size photos*
- (iii) *Certified copies of professional and Academic certificates*
- (iv) *All Academic/ Professional and transcript certificates have to be authenticated from the relevant specialized authority. Any certificate in a language other than English will have to be accompanied with a translated version.*
- (v) *Curriculum Vitae*
- (vi) *Evidence of appropriate linguistic skills in English.*
- (vii) *Accreditation of all Credentials by International Accreditation agency (EPIC/ Data Flow)*
- (viii) *Application & Registration fee (see the attached fees structure).*
- (ix) *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).

5. 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: _____