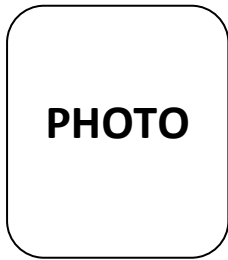

**APPLICATION FOR PRELIMINARY REGISTRATION AS
A SPECIALIST**



YEAR _____

1. PERSONAL INFORMATION:

- 1.1. Surname: _____
- 1.2. First Name: _____ Other Names: _____
- 1.3. Date of Birth: _____ Nationality: _____
- 1.4. National ID No: _____ Gender: Male Female
- 1.5. Permanent Reg. No: _____
- 1.6. Physical Address: _____
- 1.7. State: _____ County: _____ Town: _____
- 1.8. Phone No: _____ Email: _____

2. ACADEMIC QUALIFICATION:

- 2.1. Specialty/Degree/Certificate 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: _____

3. The Employer: _____

Tel No: _____ E-mail Address: _____

4. SPECIALTY TRAINING DETAILS:

4.1. Specialty for which Preliminary Registration is Sought:

4.2. Name of Accredited Training Institution/Hospital: _____

4.3. Address of Training Institution: _____

4.4. Training Program Director/Supervisor: _____

4.5. Contact Phone: _____ Email: _____

4.6. Official Start Date of Specialist Training (DD/MM/YYYY): _____

4.7. Anticipated End Date of Training (DD/MM/YYYY): _____

4.8. Is this a recognized/accredited postgraduate training program? [] Yes [] No

If yes, name the accrediting body (National/International Body):

5. Requirements

- (i) Copies of Primary Medical Degree Certificate and Transcript
- (ii) Copy of Permanent Registration Certificate
- (iii) Copy of post graduate qualification and official transcript.
- (iv) Valid Practicing License from country of origin/last practice
- (v) Certificate of Good Standing/Professional Status from ALL previous registration authorities (Issued within last 3-12 months)
- (vi) Proof of Specialist Training Enrollment/Contract (Letter from Head of Institution) Must be on official letterhead
- (vii) All credentials from foreign countries must be verified by any of the council's recognized international verification agency (EPIC, Dataflow)
- (viii) Curriculum Vitae (Detailed, including all work experience)
- (ix) Four Passport-sized Photographs
- (x) Copy of the National ID
- (xi) Application & Registration fees (see the attached fees structure)

(xii) 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)

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: _____

For Official Use:

Verified by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Recommended by:

Name: _____ Designation: _____

Signature: _____ Date: _____

Approval for Preliminary Registration:

Approved **Not Approved**

Specialty: _____ Reg. No: _____

Name: _____ Designation: _____

Signature: _____ Date: _____

To be completed by the HEAD OF THE TRAINING INSTITUTION / PROGRAM DIRECTOR

This is to certify that:

Dr. _____ has been accepted into the accredited

(Name of Specialty)

training program at _____.

(Name of Institution)

The program runs from ____ / ____ / _____ to ____ / ____ / _____.

Dr. _____ will be under continuous supervision during this training period.

We endorse their application for Preliminary Specialist Registration with the SSGMC.

Name of Head/ Director (Printed): _____

Title/Position: _____

Signature: _____ Date (DD/MM/YYYY): _____

(Official Stamp/Seal of the Institution)