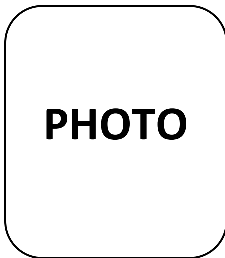
SSGMC
SOUTH SUDAN GENERAL MEDICAL COUNCIL

FORM 5

APPLICATION FOR PERMANENT REGISTRATION AS A SPECIALIST



PHOTO

YEAR ___________

1. Personal Information:

1.1. Surname: ________________________

1.2. First Name: _______________________ Other Names: ______________________________

1.3. Date of Birth: _____________________ Gender: Male ☐ Female ☐

1.4. National ID No: ________________________ Permanent Reg. No: ______________________

1.5. Physical Address: ____

1.6. State: ____________________ County: __________________ Town: ____________________

1.7. Phone No: _______________________ Email: _______________________________________

2. Academic Qualification:

2.1. Degree/ Diploma/ 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: __________________________________

2.8. The Employer: ____

2.9. Tel No: __________________________ E-mail Address: ______________________________

2.10. Specialty/ Sub-specialty applied for: ____

2.11. Post-graduate qualifications: ____

2.12. Institution: ____

2.13. Date qualified: ________________________________ Country: ________________________

Number of years of experience in specialty/ sub-specialty after obtaining postgraduate qualifications (indicate the number of years or months, name of institution(s) attended, and name of two supervisors whose address must accompany this application)

2.14. No. of years/months: ______________ Institution: ____________________________________

2.15. **Name of the Supervisor (1):** ____

P.O. Box: ____________________________ Code: _______________________________

Town: _____________________________ Country: _________________________________

Tel No: _______________________ E-mail: ____

2.16. **Name of the Supervisor (2):** ____

P.O. Box: ____________________________ Code: _______________________________

Town: _____________________________ Country: _________________________________

Tel No: _______________________ E-mail: ____

3. Requirements

(i) Copy of post graduate qualification and other official transcripts.
(ii) Evidence of completion of a minimum of 3-year rotation in a recognized training institution for Specialist recognition (as evidenced by a specialist postgraduate certification, MMeds, Fellowships, Board certifications and clinical MDs by post-graduate boards) At least One year (12 months) of a clinical rotation after 2 years post-basic specialist training period in a recognized institution for sub-specialist recognition as evidenced by certifications of trainers of the subspecialty applied for.
(iii) Supportive recommendations from two (2) referees in the relevant field.

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(iv) Specialty and sub specialty must be in the approved fields.

(v) All credentials from foreign countries must be verified by any of the council's recognized international verification agency (EPIC, Dataflow, etc.).

(vi) Application & Registration fees (see the attached fees structure)

(vii) 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)

4. 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: ______________________________