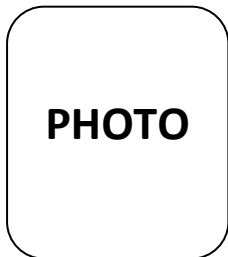

APPLICATION FOR PRIVATE PRACTICE LICENSE



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. SSGMC Reg. No: _____
- 1.6. Address: _____
- 1.7. Code: _____ Town: _____ Country: _____
- 1.8. Phone No: _____ Mobile: _____
- 1.9. Email: _____

2. Qualifications:

Dentist Medical Doctor Pharmacist

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

- 2.2. Name of authorized premises: _____
- 2.3. Tel No: _____ E-mail Address: _____

2.4. Notification for any changes of name, address and/or authorized premises: _____

2.5. Do you propose to practice on your own or to be employed full-time or part-time by a Private Practitioner? (give details)

2.6. What type of practice do you purpose to engage in?

General Practitioner:

Specialist:

2.7. Specify the discipline (if specialist): _____

New License

Renewal

License No: _____

Duration: from _____ to _____

3. Mandatory Requirements

- (i) Copies of National ID/ Passport, Permanent Registration
- (ii) Appointment letter/ Contract or letter of no objection from the employer, schedule of duties should be provided for part-time practice.
- (iii) In case of New Premises, Inspection Report should be attached.
- (iv) Application & License fees (see the attached fees structure).
- (v) 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)

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: _____