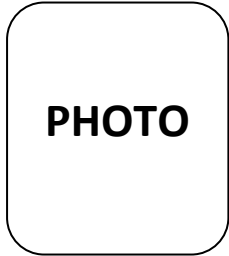

**APPLICATION FOR PROVISIONAL LICENSE FOR FOREIGN DOCTORS/
SPECIALISTS**



YEAR _____

1. Personal Information:

- 1.1. Surname: _____
- 1.2. First Name: _____ Other Names: _____
- 1.3. Date of Birth: _____ Nationality: _____
- 1.4. Passport 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. Academic Qualification:

- 2.1. Degree/ Diploma/ 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. New License **Renewal** **License No:** _____

Duration: from _____ to _____

5. Mandatory Requirements

- (i) Copy of a valid Passport
- (ii) Current colored passport size photos
- (iii) Certified copies of professional certificates and transcripts (provide official translation if not in English)
- (iv) Introduction letter/job offer from the institution
- (v) Copy of SSGMC provisional registration certificate
- (vi) Copy of current/last practice license (if renewal)
- (vii) Copy of current CV (Resume)
- (viii) Copy of a valid work permit
- (ix) Application and License fees (see the attached fees structure)
- (x) 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:

(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: _____