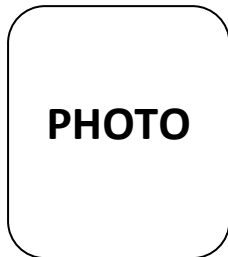

APPLICATION FOR PEER REVIEW



YEAR _____

1. Personal Information:

- 1.1. Surname: _____
- 1.2. First Name: _____ Other Names: _____
- 1.3. Date of Birth: _____ Nationality: _____
- 1.4. National ID No./ Passport No: _____ Gender: Male Female
- 1.5. 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 (please attach all the supporting evidence):
- 2.11. _____
- 2.12. _____
- 2.13. Have any arrangements been made regarding employment? (if so, give details)
- 2.14. _____

3. Mandatory Requirements

- (i) *Copy of National ID/Passport*
- (ii) *Colored passport sized photo*
- (iii) *Certified copies of professional and academic certificates*
- (iv) *(Copy of current CV*
- (v) *Evidence of postgraduate qualifications*
- (vi) *Certificate of status (good standing)*
- (vii) *Certificate of status from current regulatory authority*
- (viii) *Specialist recognition (if any) from current medical council*
- (ix) *Application fees.*
- (x) *Peer review / evaluation fees.*
- (xi) *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)

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: _____