SSGMC
SOUTH SUDAN GENERAL MEDICAL COUNCIL

FORM 2

REPUBLIC OF SOUTH SUDAN

SOUTH SUDAN GENERAL MEDICAL COUNCIL

APPLICATION FOR PERMANENT REGISTRATION AS A MEDICAL OR DENTAL PRACTITIONER

YEAR: _____

PHOTO

1 Surname ..... First Name .....

Second Name.....

2 Date of Birth ..... Nationality .....

National ID Number/Passport Number: .....

3 Address:..... Town: ..... Payam:.....

County:..... State: .....

Tel No:..... E-mail Address: .....

4 Degree, Diploma or Certificate held:.....

Date Qualified: .....

5 Name of institution: .....

Contact details:..... Website Of Institution

Tel No: ..... E-mail Address: .....

6 Name of Internship Training Facility, Tel No and E-mail Address and Period(s) of Internship:

	Training Facility	**Tel No**	**E-mail Address**	**Period of Internship**
1				From: ..... To:.....
2				From: ..... To:.....
3				From: ..... To:.....
4				From: ..... To:.....

5				From: …… To:……
6				From: …… To:……

7 Particulars and testimonials covering the period(s) of experience. ***Please list and provide/attach all supporting evidence. Only certified true copies must be provided/attached:***

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8 Name of Current Employer:

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Address:…… Town: …… Payam:……

County:…… State: ……

Tel No:…… E-mail Address: ……

Requirements

(i) *Copy of National ID/Passport*

(ii) *Four(4) colored passport sized photo with Name and Id number indicated at the back.*

(iii) *Certified copies of professional ,academic certificates and Academic Transcripts.*

(iv) *All Academic/Proffesional and transcript certificates have to be authenticated from the relevant specialized authority.Any certificate in a language other than English will have to be accompanied with a translated version.*

Evidence of passing Board's pre-registration examination (for all foreign trained)

(v) *The institution must appear in the list submitted by deans of Accredited National Medical/Dental Schools or other relevant and accredited institutions*

(iv) *Appropriately filled, stamped and signed Internship Completion Assessment Form*

(v) *Evidence of registration from partner States' Medical Boards and Councils (for those with foreign qualifications and internship training)*

(vi) *Application fees of SSP …… (South Sudanese Pounds).*

(vii) *All payments are **non-refundable** and should be made at the given **Bank details**. Evidence of payment must be submitted together with the form.*

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

PREPARED BY:

Name: .....

Designation: .....

Signature: .....

Date: .....

APPROVED ☐ **NOT APPROVED** ☐

Name: .....

Designation: .....

Signature: .....

Date: .....

RECOMMENDED BY:

Name: .....

Designation: .....

Signature: .....

Date: .....