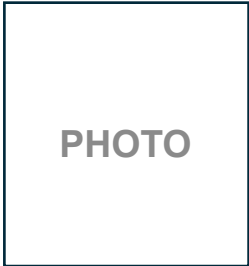




**REPUBLIC OF SOUTH SUDAN**  
**SOUTH SUDAN GENERAL MEDICAL COUNCIL**

**APPLICATION FOR PERMANENT REGISTRATION AS A PHARMACIST**



**YEAR:** \_\_\_\_\_

First Name.....

1 Surname ..... 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: .....

Number of years training undertaken .....

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:

	<b>Training Facility</b>	<b>Tel No</b>	<b>E-mail Address</b>	<b>Period of Internship</b>
1. HOSPITAL				From: ..... To: .....
2.				From: ..... To: .....
3. INDUSTRIAL				From: ..... To: .....
4.				From: ..... To: .....

5. RETAIL/ COMMUNITY				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: .....

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.  
*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.*
- (iv) Evidence of passing Board’s pre-registration examination (for all foreign trained)  
*The institution must appear in the list submitted by deans of Accredited National Medical/Dental Schools or other relevant and accredited institutions*
- (v) 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**

<b>PREPARED BY:</b>			
Name:.....		<b>APPROVED</b> <input type="checkbox"/>	<b>NOT APPROVED</b> <input type="checkbox"/>
Designation:.....			
Signature:.....			
Date: .....		Name:.....	

<b>RECOMMENDED BY:</b>			
Name:.....		Designation: .....	
Designation:.....		Signature:.....	
Signature:.....			
Date: .....		Date:.....	

Approval for admittance on Permanent/Provisional Register of Pharmacists granted at council meeting on ..... day of .....20.....	
Registration Number .....	
Dated .....	Signed.....
	Registrar