

ATTENTION:

- Applicants are required to fill in this form and to be submitted with updated CV, copies of academic certificates and passport in pdf or jpeg format to medical.recruitment@moh.gov.bn
- Please ensure the advertisement code is filled in. (**only applications with quoted advert will be processed**)

POST APPLIED:	
ADVERTISEMENT CODE:	

A. APPLICANT DETAILS					
Full Name (as in your passport)				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced..... <input type="checkbox"/> Widowed	
Passport No		Birth Date:	Country of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Place of Issue		Age:	Nationality:	Religion:	Race:
Permanent Address:				Post Code:	
Mailing Address:				Post Code:	
Contact No	(Home)	(Mobile)	(Office)	Email:	
Occupation				Employer	
Dependents	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Children: <input type="text"/> Boys <input type="text"/> Girls <input type="checkbox"/> Others:			Total No. of Dependents:	
				Desired Pay Range Per Month	
SPOUSE'S DETAIL					
Name:				Nationality (Please Specify):	
				Birth Date:	
Occupation				Employer	

B. CURRENT JOB DETAILS						
Employer						
Address					Contact No	
Job Position		Employment Period		-	Type of Appointments *	
					Salary/ Pay Rate	\$ per month
Other Important Details						
*Please indicate the Type of Appointment as follows (you may indicate more than one if applicable): F- Full Time P- Part-Time C- Contract L- Locum D- Daily Pay I- Intern Others						

C. ACADEMIC QUALIFICATIONS <small>[Basic Medical Degree , all relevant Postgraduate Qualifications and Professional Membership]</small>			
<small>[please attach copy of certificates together with this form]</small>			
No.	Qualifications (including place of study)	Type of Course (Full-time/Part-time/Distance Learning)	Date Certified (D-M-Y)
1			/ /
2			/ /
3			/ /
4			/ /
5			/ /
6			/ /
7			/ /
8			/ /
9			/ /
10			/ /

D. CURRENT PROFESSIONAL PRACTICE REGISTRATION		
<small>[Please attach copy of certificates together with this form]</small>		
No	Details	Date Certified (D-M-Y)
1		/ /
2		/ /
3		/ /
4		/ /

E. REFEREES			
	REFEREE #1	REFEREE #2	REFEREE #3
NAME			
Job Title (Workplace)			
Relationship			
Contact No.			
Email			

F. EMPLOYMENT HISTORY	
<i>[please use additional papers to list down your job history in chronological order with job descriptions/duties and responsibilities using the format below]</i>	
Job Title (BLOCK LETTERS)	
Employer (please state private or government)	
Employment Period (please attach Letters of Service/Proof of Employment)	
Reasons For Leaving	

G. CURRENT JOB DESCRIPTION
<p>Please provide a short summary about the work you are doing now:</p> <ul style="list-style-type: none"> • In what capacity you are being employed including start date of current post. • Your clinical skills and responsibilities (eg. Day to day clinical work – outpatient, wards, operating theatres; emergency cases or referrals; administrative, academic, various clinical cases that you have encountered and managed, etc.) • Information about the hospital / clinic you are working at (size, workload, number of beds, etc) • Other relevant information <p><i>[please attach your response on a separate sheet of paper if not enough space]</i></p>

H. PERSONAL STATEMENT

Why do you want to work in Brunei?

[please attach your response on a separate sheet of paper if not enough space]

How did you hear about us?

Availability to start once selected?

I. DECLARATION

The above information is true to the best of my knowledge. In submitting this form, I understand that false statements will disqualify me for employment.

I understand that consideration for employment is contingent on the result of a reference and background check. Therefore, I hereby authorize Ministry of Health, Brunei Darussalam and/or affiliates to investigate the truthfulness of all statements made in this form, contact my former employers or any other persons, who can verify information concerning this form, and I release and assure each person and organization from liability for providing information to Ministry of Health, Brunei Darussalam.

Please return this form to:

Human Resource Office
Ministry of Health
Commonwealth Drive
Bandar Seri Begawan BB3910
Brunei Darussalam

Email: medical.recruitment@moh.gov.bn

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Signature of Applicant
(Unsigned Form is not valid)

Insert Passport
Photo Here