

REGISTRATION NO. (For office use only)

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**BMB 1**

## BRUNEI MEDICAL BOARD

### MEDICAL PRACTITIONERS AND DENTISTS ACT REVISED EDITION 1984 (CAP.112) LAWS OF BRUNEI

### APPLICATION FOR FULL REGISTRATION

#### HOW TO COMPLETE THIS APPLICATION FORM

1. Please print boldly using block letters. All sections must be completed.
2. Enclose 2 recent colour passport-size photographs and 1 photocopied set of supporting documents. Documents required are listed at the bottom of the form under "For Office Use." Certificates/letters of Good Standing should not be more than 6 months old. For first registration with the Brunei Medical Board, original documents must be presented for sighting.
3. For Private Practice applicants, please enclose a cash registration fee of B\$50. This fee is refundable upon unsuccessful application.
4. This application is the property of the BRUNEI MEDICAL BOARD. Supporting documents will NOT be returned.

\*Please tick appropriate box

#### PERSONAL DETAILS

FULL NAME:			
DATE OF BIRTH: / /		*SEX: M <input type="checkbox"/> F <input type="checkbox"/>	
NATIONALITY:			
PASSPORT NO:		COUNTRY OF ISSUE:	
BRUNEI I/C NO:		*COLOUR: Y <input type="checkbox"/> P <input type="checkbox"/> G <input type="checkbox"/>	
HOME ADDRESS:		POSTAL ADDRESS (if different from home address):	
COUNTRY: POSTCODE:		COUNTRY: POSTCODE:	
TELEPHONE:	FACSMILE:	MOBILE:	
E-MAIL:			

#### INTENDED PLACE OF PRACTICE

ADDRESS OF PRINCIPAL PLACE OF PRACTICE:		
POSTCODE:		<b>BRUNEI DARUSSALAM</b>
TELEPHONE:	FACSMILE:	PAGER:
*TYPE OF PRACTICE: GOV'T <input type="checkbox"/>	PRIVATE SOLO <input type="checkbox"/>	PRIVATE GROUP <input type="checkbox"/>
DATE OF COMMENCEMENT: / /		
DEPARTMENT (if applicable):		

**OTHER PLACES OF PRACTICE (if any)**

ADDRESS	POSTCODE	TEL/FAX	TYPE OF PRACTICE

**MEDICAL/DENTAL QUALIFICATIONS****FIRST DEGREE**

DATE OF COMMENCEMENT	QUALIFICATION/DEGREE	INSTITUTION	COUNTRY	DATE OF COMPLETION
/ /				/ /

**POST-GRADUATE QUALIFICATIONS (if any)**

DATE OF COMMENCEMENT	QUALIFICATION	SPECIALTY	INSTITUTION	DATE OF COMPLETION
/ /				/ /
/ /				/ /
/ /				/ /
/ /				/ /

**REGISTRATION WITH OTHER MEDICAL BOARD/COUNCIL**

NAME OF BOARD/COUNCIL	COUNTRY	DURATION
		From / / to / /
		From / / to / /
		From / / to / /

**WORK EXPERIENCE/EMPLOYMENT HISTORY**

DURATION	EMPLOYER/HOSPITAL	POSITION/DUTIES	DEPARTMENT
From / / to / /			
From / / to / /			
From / / to / /			
From / / to / /			
From / / to / /			
From / / to / /			
From / / to / /			

**MEMBERSHIP OF PROFESSIONAL SOCIETY/ASSOCIATION**

NAME OF SOCIETY:
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**DOCTOR/DENTIST PARTNER/S IN PRIVATE PRACTICE (if any)**

NAME:	
BRUNEI I.C. NO:	COLOUR: Y <input type="checkbox"/> P <input type="checkbox"/> G <input type="checkbox"/>
BRUNEI MEDICAL BOARD REGISTRATION NO:	
NAME:	
BRUNEI I.C. NO:	COLOUR: Y <input type="checkbox"/> P <input type="checkbox"/> G <input type="checkbox"/>
BRUNEI MEDICAL BOARD REGISTRATION NO:	
NAME:	
BRUNEI I.C. NO:	COLOUR: Y <input type="checkbox"/> P <input type="checkbox"/> G <input type="checkbox"/>

BRUNEI MEDICAL BOARD REGISTRATION NO:

**TYPES OF SERVICES OFFERED AT PRACTICE** (include supporting documents of competency)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

**PROCEDURES CONDUCTED AT SURGERY** (include supporting documents of competency)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

**PROFESSIONAL CONDUCT**

Has the applicant ever been the subject of an inquiry or an investigation by a licensing authority involving an allegation of professional misconduct, incompetence, incapacitation or any like allegation?

YES  NO

Is the applicant currently the subject of an inquiry or an investigation by a licensing authority involving an allegation of professional misconduct, incompetence, incapacitation or any like allegation?

YES  NO

Does the applicant appear in the records of a licensing authority as having been subjected to reduced or cancelled privileges by a hospital/clinic due to incompetence, negligence, incapacitation or any form of professional misconduct?

YES  NO

\*If **YES** has been answered to any of the questions above, please provide all relevant information and documentation.

**\*ENGLISH/MALAY LANGUAGE PROFICIENCY**

English was the language of instruction in previous studies/employment. (if not, please state : \_\_\_\_\_)

Will sit/have sat for an English/Malay proficiency test.

DATE TAKEN	TEST NAME	RESULT (if known)
/ /		
/ /		

**DECLARATION & SIGNATURE**

I hereby declare that the above information is true and complete. I recognise that it is my responsibility to provide any necessary documentation to support my application and I authorise the Brunei Medical Board to obtain further relevant documentation. I acknowledge that the Brunei Medical Board reserves the right to change or reverse any decision regarding registration on the basis of incorrect or incomplete information.

SIGNATURE OF APPLICANT:

Date:     /     /

**FOR OFFICE USE**

Received:     /     /

Payment:     1) Amount:

                  2) Receipt No:

                                  3) Date:

Passport Photos   

- Documents:
- 1) Proof of offer of clinical job
  - 2) Copy of basic medical degree
  - 3) Proof of post-housemanship clinical experience
  - 4) Certificate of Registration
  - 5) Copy of post-graduate certificates
  - 6) Certificate/Letter of Good Standing
  - 7) Curriculum Vitae
  - 8) Proof of identity
  - 9) Medical Fitness Certificate
  - 10) Documents/certificates related to services provided/procedures conducted (Private Practice

Processed by: \_\_\_\_\_

Approved   

Rejected   

Comments: \_\_\_\_\_

Signature:

Date:     /     /