

REGISTRATION NO. (For office use only)

	-			-					
--	---	--	--	---	--	--	--	--	--

**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 set of supporting documents. If in Private Practice, enclose a Letter of Good Standing issued not more than 6 months prior to date of application and a Medical Fitness Certificate issued by a Government Doctor. (Faxed copies are not acceptable)
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:
------------------

**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 <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
*If <b>YES</b> has been answered to any of the questions above, please provide all relevant information and documentation.

**\*ENGLISH/MALAY LANGUAGE PROFICIENCY**

<input type="checkbox"/> English was the language of instruction in previous studies/employment. (if not, please state : _____)		
<input type="checkbox"/> Will sit/have sat for an English/Malay proficiency test.		
DATE TAKEN	TEST NAME	RESULT (if known)
/ /		
/ /		

