

CERTIFICATE NO. (For office use only)

BMB 2

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BRUNEI MEDICAL BOARD

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

APPLICATION FOR ANNUAL PRACTISING CERTIFICATE

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, photocopies of all pages of passport together with a list of dates of absence from Brunei Darussalam since 1 December last year, a Medical Fitness Certificate issued by a Government Doctor if applicant above 55 years, a list of the medical services and clinical procedures offered at place of practice together with relevant certificates to support this. (Fax copies are not acceptable). Also copy of CME log book and supporting certificates of attendance. A minimum of 30 CME points is required.
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:			BRUNEI DARUSSALAM
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.

***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)
/ /		
/ /		

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) Photocopies of all pages of passport

 2) List of dates of absence from Brunei Darussalam since 1 December last year

 3) Medical Fitness Certificate (if applicable)

 4) List of services / procedures

 5) Documents / certificates related to 4

 6) CME log book and supporting certificates

Processed by: _____

Approved

Rejected

Comments: _____

Signature:

Date: / /