

REGISTRATION NO. (For office use only)

**BMB 3**

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## BRUNEI MEDICAL BOARD

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

### APPLICATION FOR TEMPORARY REGISTRATION

#### HOW TO COMPLETE THIS APPLICATION FORM

1. This form is to be completed by the EMPLOYER of the applicant, if non-government.
2. Please print boldly using block letters. All sections must be completed.
3. 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)
4. For Private Practice applicants, please enclose a cash registration fee of B\$50. This fee is refundable upon unsuccessful application.
5. This application is the property of the BRUNEI MEDICAL BOARD. Supporting documents will NOT be returned.

\*Please tick appropriate box

#### PERSONAL DETAILS OF DOCTOR TO BE REGISTERED

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:	E-MAIL:

#### INTENDED PLACE OF PRACTICE

ADDRESS OF PRINCIPAL PLACE OF PRACTICE:			
COUNTRY:	POSTCODE:	TELEPHONE:	FACSMILE:
*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 / /
		From / / to / /

**WORK EXPERIENCE/EMPLOYMENT HISTORY**

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

**MEMBERSHIP OF PROFESSIONAL SOCIETY/ASSOCIATION:**

NAME OF SOCIETY:
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**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)
/ /		
/ /		

**PARTICULARS OF EMPLOYER IF NON-GOVERNMENT**

FULL NAME:		
BRUNEI MEDICAL BOARD FULL REGISTRATION NO.:		
DATE OF REGISTRATION: / /		
ADDRESS OF PRACTICE:		
COUNTRY:	POSTCODE:	
TELEPHONE:	FACSMILE:	E-MAIL:
*TYPE OF PRACTICE: GOV'T <input type="checkbox"/>	PRIVATE SOLO <input type="checkbox"/>	PRIVATE GROUP <input type="checkbox"/>
If Private, state ANNUAL PRACTISING CERTIFICATE NO.:		

**OTHER PLACES OF PRACTICE:**

ADDRESS	COUNTRY	POSTCODE	TEL/FAX	TYPE OF PRACTICE

**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:				

**\*REASON FOR APPLICATION**

<input type="checkbox"/> Relieving Doctor** in Private Practice
<input type="checkbox"/> Trial period before full acceptance in Private Practice
<input type="checkbox"/> Visiting Medical Team
<input type="checkbox"/> Locum Tenens in Government Service
<input type="checkbox"/> Daily paid in Government Service
<input type="checkbox"/> Research / Training / Teaching
**NAME OF DOCTOR RELIEVED:
**BRUNEI MEDICAL BOARD FULL REGISTRATION NO.:

