



BMB REGISTRATION NO.

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

**How to complete this application form**

- Read and **complete all questions**
- Ensure that **all pages** and required **attachments** are submitted to Brunei Medical Board
- Use a **blue** pen only
- Print clearly in **BLOCK LETTERS**
- Place X in **all** applicable boxes:

**Privacy and Confidentiality**

- The Brunei Medical Board and BMO are committed to protecting personal information as private and confidential.

**SECTION A: Personal details**

Title:  
MR  MRS  MISS  MS  DR  Other:

Full name:

Date and Country of Birth:  -  -  Age:  year Sex: Male  Female

Nationality:  Passport No:  Country of Issue:

Brunei I/C No:  Colour: Yellow  Purple  Green

Marital Status: Single  Married  Divorced  Widow  Race:  Religion:

**SECTION B: Contact information**

**What is your current contact details?**

Provide current contact details below and place an  next to your preferred contact phone number

Office/Business hours  Mobile

After hours

Email



**What is your current residential address?**

Residential address **cannot** be a PO Box.

Post Code

**What is your current mailing address?**

Your mailing address is used for postal correspondence

-  My residential address
-  Other (*provide your mailing address below*)


**What is your principal place of practice?**

The address at which you predominantly practice the profession and it **cannot** be a PO Box.


Post Code

Telephone

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Facsimile

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Type of practice: Government  Private

Date of Commencement:

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	---	----------------------	----------------------	---	----------------------	----------------------	----------------------	----------------------

Department (if Government):

--

Unit (if applicable) :

--

**Other places of practice (if any)**

Address	Post code	Contact & Fax number	Type of practice

Your position:

--

Type of Appointment:

- Permanent  Locum
- Contract  Daily Paid
- Month to Month

**SECTION C: Declaration and Signature**

I hereby declare that the above information is true and complete. I recognize that it is my responsibility to provide any necessary documentation to support my application and I authorize 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. I hereby also authorize the Brunei Medical Board and BMO to release any information and/or relevant documentation for the purposes of the Medical and Dental Practitioners Act or any relevant legislation herewith.

Signature of applicant:

--

Date:

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	---	----------------------	----------------------	---	----------------------	----------------------	----------------------	----------------------

**SECTION D: Checklist**

No.	Additional documents	Attached
1	One (1) colour passport photo (with name written at the back)	<input type="checkbox"/>
2	Copy of Certificate of any recent postgraduate qualifications or trainings (if applicable)	<input type="checkbox"/>
3	Evidence of at least 30 CME points plus supporting documents	<input type="checkbox"/>
4	Valid Medical fitness certification from Occupational Health Section, Ministry of Health Validity date: _____	<input type="checkbox"/>
5	<b>Additional for private sector:</b>	
5.1	List of services/procedures	<input type="checkbox"/>
<b>Payment</b>		
1	Registration Fee <i>(If applicable)</i>	<input type="checkbox"/>
2	Administrative Fee	<input type="checkbox"/>

Type of Application for Annual Practicing Certificate

New Renewal 

Please hand in this form with required documentations and payment (if applicable) to:

**BRUNEI MEDICAL BOARD**  
Unit 2G4:02  
4<sup>th</sup> Floor  
Ong Sum Ping Condominium  
Brunei Darussalam  
BA 1311

~~~~~  
Email : bmb.brunei@moh.gov.bn