Boards Management Office	Ministry of Health Brunei Darussalam	**T&CM**
REGISTRATION NO. (for office use only)		**Application for practitioners registration**

How to complete this application form	*Privacy and Confidentiality*
○ Read and **complete all questions** ○ Ensure that **all pages** and required **attachments** are returned to Boards Management Office (BMO) ○ Use a **blue** pen only ○ Print clearly in **BLOCK LETTERS** ○ Place X in **all** applicable boxes: ☒ ○ Only completed application form with the required supporting documents will be processed. ○ Please refer to 'Guidelines for Registration of Traditional and Complementary Medicine Practitioners in Brunei Darussalam' which can be accessed at www.moh.gov.bn, before filling up the application form.	○ The T&CM Unit Ministry of Health and BMO are committed to protecting personal information as private and confidential.

SECTION A: Application inclusions

Which type(s) of practice are you applying for registration in?

Mark ☒ on the option applicable to your application

1. Traditional Medicine

☐ Malay ☐ Chinese ☐ Indian ☐ Others, please specify: _____

2. Complementary Medicine

☐ Acupuncture ☐ Chiropractor ☐ Cupping ☐ Herbal Dispenser

☐ Homeopathy ☐ Massage ☐ Osteopathy ☐ Reflexology

☐ Others, please specify: _____

SECTION B: Personal details

Title:
MR ☐ MRS ☐ MISS ☐ MS ☐ Other: _____

Full name: _____

Date and Country of Birth: ☐☐-☐☐☐-☐☐☐☐ _____ Age: _____ year Gender: Male ☐ Female ☐

Nationality: _____ Passport No: _____ Country of Issue: _____

Brunei I/C No: _____ Colour: Yellow ☐ Purple ☐ Green ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Race: _____ Religion: _____

SECTION C: Contact information

What are your contact details?

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

Office/Business hours ☐

Mobile ☐

After hours ☐

Email

What is your residential address?

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

Post Code

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

Facsimile

Type of practice: Government ☐ Private Solo ☐ Private Group ☐

Date of Commencement: - -

Department (if Government):

Other places of practice (if any)

Address	Post code	Contact & Fax number	Type of practice

What is your mailing address?

Your mailing address is used for postal correspondence

☐ ☞ My residential address ☐ ☞ My principal place of practice

☐ ☞ Other (***provide your mailing address below***)

Post Code

SECTION D: Qualification for the profession

i. Qualification **must be relevant** to the type of T&CM practice that is provided by the practitioner.
ii. A **true certified copy** of all relevant qualification certificates, including certificate of registration with any professional body **must be submitted** with the application form. **Original certificate must be shown** for documentation.
iii. Certificate **must be in English or Malay** language and certified by the country from which the certificate was issued.

What are the details of your qualifications and examinations/ assessments?

Primary T&CM qualification and examination/assessments

Title of qualification

Name of institution (University/College/Examining body)

Country

Commencement date: - -

Completion date: - -

Additional and/or other T&CM qualification and examination/assessments (if any)

Title of qualification

Name of institution (University/College/Examining body)

Country

Commencement date: - -

Completion date: - -

SECTION E: Registration history

What is your health practitioner registration history?

If you have been registered outside of Brunei Darussalam, the Board requires a Certificate of Registration Status or Certificate/Letter of Good Standing from each licensing authority outside of Brunei Darussalam in which you are currently, or have previously been registered as a health practitioner **during the past ten years**

Most recent registration

Name of Board/Council:

Country: Registration number:

Profession:

Period of registration: - - to - -

Additional registration

Name of Board/Council:

Country: Registration number:

Profession:

Period of registration - - to - -

SECTION F: Work history

What is your full practice history?

You **must** attach to your application a **signed and dated** curriculum vitae that describes your full practice history and any clinical or skills training undertaken.

Work Experience / Employment History

Duration	Employer and Country	Position/Duties
From DD-MM-YYYY To DD-MM-YYYY		
From DD-MM-YYYY To DD-MM-YYYY		
From DD-MM-YYYY To DD-MM-YYYY		
From DD-MM-YYYY To DD-MM-YYYY		
From DD-MM-YYYY To DD-MM-YYYY		

SECTION G: Suitability Statements

Do you currently hold Membership of Professional Society/ Association?

YES ☐ ☞ ***Provide details below*** NO ☐ ☞ ***Go to the next question***

Name of Society/Association and Country:

Registration number:

PROFESSIONAL CONDUCT	
a) Have you 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 ☐
b) Are you 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 ☐
c) Have you ever 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, you **must** attach all relevant information and documentation.

SECTION H: Declaration and 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 T&CM Unit, Ministry of Health to obtain further relevant documentation. I acknowledge that the T&CM Unit, Ministry of Health reserves the right to change or reverse any decision regarding registration on the basis of incorrect or incomplete information, resulting no supporting letter will be issued to Labour Department. I will comply with any codes and standards of practice that is issued by the Ministry of Health. Should I change my place of practice, name or address, I will inform the T&CM Unit, Ministry of Health within 30 days of such change.

Signature of applicant:

Date: DD-MM-YYYY

SECTION I: Checklist

No.	Additional documents	Attached
1	One (1) colour passport photo (with name written at the back)	☐
2	Proof of identity (passport, or Brunei identity card if Brunei citizen)	☐
3	Up-to-date Curriculum Vitae	☐
4	Proof of certificate of T&CM qualification ☐ Certified ☐ Not certified ☐ Original certificate shown	☐
5	Certificate of practice registration ☐ Certified ☐ Not certified ☐ Original certificate shown	☐
6	Valid practicing certificate ☐ Certified ☐ Not certified ☐ Original certificate shown	☐

Please hand in this form with payment and required attachments and documentations to:

T&CM Unit
Boards Management Office
BLK 2G3:01, Ong Sum Ping Condominium
Jalan Ong Sum Ping
Bandar Seri Begawan
Negara Brunei Darussalam

☎ +673 2230025 E✉ : tcm_brunei@moh.gov.bn

SECTION J: *FOR OFFICE USE ONLY*

Date received: | | | - | | | - | | | | |

Received by:

Signature

Evaluation outcome

☐ Fulfill the requirement and registration approved.

☐ Do not fulfill the requirement and registration rejected.

Comments:

Evaluated by:

Practitioner Number:

Signature and Stamp:

Date: | | | - | | | - | | | | |