REGISTRATION NO. (For office use only)

	-							

BMB 3

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 photocopied set of supporting documents. Documents required are listed at the bottom of the form under "For Office Use." Certificates/letters of Good Standing should not be more than 6 months old. For first registration with the Brunei Medical Board, original documents must be presented for sighting.
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 ☐ F ☐
NATIONALITY:	
PASSPORT NO:	COUNTRY OF ISSUE:
BRUNEI I/C NO:	*COLOUR: Y ☐ P ☐ G ☐
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 ☐	PRIVATE SOLO ☐	PRIVATE GROUP ☐
DATE OF COMMENCEMENT: / /			

DEPARTMENT (if applicable):

OTHER PLACES OF PRACTIVE (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:

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 ☐ NO ☐
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 ☐ NO ☐
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 ☐ NO ☐
*If **YES** has been answered to any of the questions above, please provide all relevant information and

documentation.

***ENGLISH/MALAY LANGUAGE PROFICIENCY**

☐ English was the language of instruction in previous studies/employment. (if not, please state :_____)		
☐ 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 ☐	PRIVATE SOLO ☐	PRIVATE GROUP ☐
If Private, state ANNUAL PRACTISING CERTIFICATE NO.:		

OTHER PLACES OF PRACTICE:

ADDRESS	COUNTRY	POSTCODE	TEL/FAX	TYPE OF PRACTICE

DOCTOR/DENTIST PARTNER/S IN <u>PRIVATE PRACTICE</u> (if any)

NAME:						
BRUNEI I.C. NO:	COLOUR:	Y	☐	P	☐	G ☐
BRUNEI MEDICAL BOARD REGISTRATION NO:						
NAME:						
BRUNEI I.C. NO:	COLOUR:	Y	☐	P	☐	G ☐
BRUNEI MEDICAL BOARD REGISTRATION NO:						
NAME:						
BRUNEI I.C. NO:	COLOUR:	Y	☐	P	☐	G ☐
BRUNEI MEDICAL BOARD REGISTRATION NO:						

***REASON FOR APPLICATION**

☐ Relieving Doctor** in Private Practice
☐ Trial period before full acceptance in Private Practice
☐ Visiting Medical Team
☐ Locum Tenens in Government Service
☐ Daily paid in Government Service
☐ Research / Training / Teaching
**NAME OF DOCTOR RELIEVED:

**BRUNEI MEDICAL BOARD FULL REGISTRATION NO.:
***PERIOD APPLIED FOR**
NO. OF WEEKS:
DATE OF COMMENCEMENT : / /
PROPOSED DATE OF COMPLETION : / /

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 this application and I authorise the Brunei Medical Board to obtain further relevant documentation if needed. 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 EMPLOYER IF NON-GOVERNMENT: SIGNATURE OF APPLICANT IF FOR GOVERNMENT:	Date: / /

FOR OFFICE USE

Received: / /

Payment: 1) Amount:

2) Receipt No: 3) Date:

Passport Photos ☐

Documents:
1) Proof of offer of clinical job ☐
2) Copy of basic medical degree ☐
3) Proof of post-housemanship clinical experience ☐
4) Certificate of Registration ☐
5) Copy of post-graduate certificates ☐
6) Certificate/Letter of Good Standing ☐
7) Curriculum Vitae ☐
8) Proof of identity ☐
9) Medical Fitness Certificate ☐
10) Documents/certificates related to services provided/procedures conducted (Private Practice ☐

Processed by: _____

Approved ☐ Rejected ☐

Comments: _____

Signature: Date: / /