

APPLICATION FORM

INSTRUCTIONS:

1. Applicants are required to fill in this form and to be submitted with updated CV, copies of academic certificates and passport in pdf or jpeg format to medical.recruitment@moh.gov.bn
2. Please ensure the advertisement code is filled in.
3. Applicants is to submit the following documents along with this form:
 - a) *Curriculum Vitae*
 - b) *Basic Medical Degree.*
 - c) *Evidence of Completion of Internship/Pre-registration/Foundation Training.*
 - d) *Full Medical Registration of practice after completion of Internship/Pre-registration/Foundation Training or equivalent registration.*
 - e) *All relevant Postgraduate Qualifications and Professional Membership as listed in Section B.*
 - f) *Current medical practicing license as listed in Section C.*
 - g) *Letters of Service/Proof of Employment as Listed in Section E.*

POST APPLIED:	
ADVERTISEMENT CODE:	

A. APPLICANT DETAILS				
Full Name (as in your passport):		Insert Passport Photo Here		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Nationality:	Passport No:			Place of Issue :
Birth Date:	Age:			Country of Birth:
Religion:	Race:			
Permanent Address:				Post Code:
Mailing Address:		Post Code:		
Contact No	(Home)	(Mobile)	(Office)	
Email:				
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Dependents	<input type="checkbox"/> Father <input type="checkbox"/> Mother		Total No. of Dependents:	
	<input type="checkbox"/> Children: <input style="width: 40px;" type="text"/> Boys <input style="width: 40px;" type="text"/> Girls		Desired Pay Range Per Month:	
	<input type="checkbox"/> Others:			
SPOUSE'S DETAIL				
Name:		Birth Date:		
Occupation:		Employer :		

B. ACADEMIC QUALIFICATIONS <i>[Basic Medical Degree , all relevant Postgraduate Qualifications and Professional Membership]</i> <i>[please attach copy of certificates together with this form]</i>			
No.	Qualifications & place of study	Type of Course (Full-time/Part-time/Distance Learning)	Date Certified (D-M-Y)
1			/ /
2			/ /
3			/ /
4			/ /
5			/ /
6			/ /
7			/ /
8			/ /
9			/ /
10			/ /

C. CURRENT MEDICAL/PROFESSIONAL PRACTICE REGISTRATION (PRACTICING LICENCE) <i>[Please attach copy of certificates together with this form]</i>		
No	Details	Date Certified (D-M-Y)
1		/ /
2		/ /
3		/ /

D. CURRENT JOB DETAILS							
Employer							
Address						Contact No	
Job Position		Employment Period				Type of Appointments *	
						Salary/ Pay Rate	\$ per month
Job Description	Please provide a short summary about the work you are doing now: <ul style="list-style-type: none"> In what capacity you are being employed including start date of current post. Your clinical skills and responsibilities (eg. Day to day clinical work – outpatient, wards, operating theatres; emergency cases or referrals; administrative, academic, various clinical cases that you have encountered and managed, etc.) Information about the hospital / clinic you are working at (size, workload, number of beds, etc) Other relevant information 						

G. DECLARATION & CONSENT

The above information is true to the best of my knowledge. In submitting this form, I understand that false statements will disqualify me for employment.

I understand that consideration for employment is contingent on the result of a reference and background check. Therefore, I hereby authorize Ministry of Health, Brunei Darussalam, its authorized affiliates, agents and subsidiary acting on its behalf to verify information, documentation and background verification presented in my application form including but not limited to education, employment and licenses.

Ministry of Health, Brunei Darussalam, its authorized affiliates, agents and subsidiary acting on its behalf may investigate the truthfulness of all statements made in my application form to contact my former employers or any other persons, who can verify information provided in the form. The information/documentation may contain but is not limited to grades, dates of attendances, grade point average degree, diploma certification employment tenure, license attained, status of license, place of issue and any other information deemed necessary to conduct verification of the information / documentation provided.

I hereby release all person or entities requesting or supplying such information from any liability arising from such disclosure. I am willing that a photocopy of this autorisation be accepted with the same authority as the original. I further understand and acknowledge that this statement of consent will remain valid for a period of two years from the date signed.

FULL NAME:.....
(in BLOCK letters)

Passport / Identity Card Number:

.....
Signature

.....
Date