



REGISTRATION NO. (for office use only)

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

How to complete this application form

- 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:

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 Widowed Race: Religion:

SECTION B: 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
<input style="width: 100%;" type="text"/> <input type="checkbox"/>	<input style="width: 100%;" type="text"/> <input type="checkbox"/>
After hours	
<input style="width: 100%;" type="text"/> <input type="checkbox"/>	
Email	
<input style="width: 100%;" type="text"/>	

What is your residential address?

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

<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>

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 <input type="text"/>	Facsimile <input type="text"/>
Type of practice: Government <input type="checkbox"/> Private Solo <input type="checkbox"/> Private Group <input type="checkbox"/>	
Date of Commencement: <input type="text"/>	
Department (if Government): <input type="text"/>	

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

<input type="checkbox"/>  My residential address	<input type="checkbox"/>  My principal place of practice
<input type="checkbox"/>  Other (<i>provide your mailing address below</i>)	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
Post Code <input type="text"/>	

SECTION C: Qualification for the profession

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

Primary medical qualification and examination/assessments (First Degree)

Title of qualification	<input type="text"/>
Name of institution (University/College/Examining body)	<input type="text"/>
Country	<input type="text"/>
Commencement date: <input type="text"/>	Completion date: <input type="text"/>

Additional medical Post-Graduate qualification and examination/assessments (if any)

Title of qualification	
<input type="text"/>	
Name of institution (University/College/Examining body)	
<input type="text"/>	
Country	
<input type="text"/>	
Commencement date:	Completion date:
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

SECTION D: 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	
<input type="text"/>	
Country	
<input type="text"/>	
Profession	
<input type="text"/>	
Period of registration	to
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

Additional registration	
Name of Board/Council	
<input type="text"/>	
Country	
<input type="text"/>	
Profession	
<input type="text"/>	
Period of registration	to
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

SECTION E: 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/Hospital	Position/Duties	Department
From <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
To <input type="text"/> - <input type="text"/> - <input type="text"/>			
From <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
To <input type="text"/> - <input type="text"/> - <input type="text"/>			
From <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
To <input type="text"/> - <input type="text"/> - <input type="text"/>			

From [][] - [][] - [][][][]			
To [][] - [][] - [][][][]			
From [][] - [][] - [][][][]			
To [][] - [][] - [][][][]			

SECTION F: Suitability Statements

Do you currently hold Membership of Professional Society/ Association?

NO  *Go to the next question*

YES  *Provide details below*

Name of Society/Association and Country

PROFESSIONAL CONDUCT		YES	NO
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?		<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>

*If **YES** has been answered to any of the questions above, you **must** attach all relevant information and documentation.

SECTION G: 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 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:

SECTION H: Checklist

No.	Additional documents	Attached
1	One (1) colour passport photo (with name written at the back)	<input type="checkbox"/>
2	Proof of identity (passport, or Brunei identity card if Brunei citizen)	<input type="checkbox"/>
3	Up-to-date Curriculum Vitae	<input type="checkbox"/>
4	Proof of post-housemanship/internship clinical experience	<input type="checkbox"/>
5	Certificate of Registration with current Medical Licensing Authority	<input type="checkbox"/>

6	Copy of post-graduate qualifications	<input type="checkbox"/>
7	Certificate/Letter of Good Standing not more than 6 months old	<input type="checkbox"/>
8	Medical Fitness Certificate issued by a Ministry of Health approved Occupational Health Practitioner	<input type="checkbox"/>
9	Proof of offer of clinical job	<input type="checkbox"/>
Payment		
i	Registration Fee of B\$50.00 (cash)	<input type="checkbox"/>

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

**Secretariat
BOARDS MANAGEMENT OFFICE
2nd Floor, Ministry of Health
Commonwealth Drive
Brunei Darussalam**

☎ +673 2380170 Fax : +673 2382032

SECTION I: FOR OFFICE USE ONLY

Date received: - -

Payment:

1. Amount: Date: - -

2. Receipt No.:

Processed by:

Registration approved: Registration rejected:

Type of Registration endorsed by the Board

Full Provisional Conditional Temporary

Comments:

Signature and Stamp: Date: - -