

REGISTRATION NO. (for office use only)

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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:
- 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.

Privacy and Confidentiality

- 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:

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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 <input type="text"/> <input type="checkbox"/>	Mobile <input type="text"/> <input type="checkbox"/>
After hours <input type="text"/> <input type="checkbox"/>	
Email <input type="text"/>	

What is your residential address?

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

<input type="text"/>
<input type="text"/>
<input type="text"/>
Post Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

What is your principal place of practice?

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

<input type="text"/>
<input type="text"/>
<input type="text"/>
Post Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Telephone <input type="text"/> <input type="text"/>	Facsimile <input type="text"/> <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"/> <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"/>	
Department (if Government): <input type="text"/>	

Other places of practice (if any)

Address	Post code	Contact & Fax number	Type of practice
<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"/>	<input type="text"/>	<input type="text"/>

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

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

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

*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:
[][] - [][] - [][][][]

SECTION I: 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 certificate of T&CM qualification <input type="checkbox"/> Certified <input type="checkbox"/> Not certified <input type="checkbox"/> Original certificate shown	<input type="checkbox"/>
5	Certificate of practice registration <input type="checkbox"/> Certified <input type="checkbox"/> Not certified <input type="checkbox"/> Original certificate shown	<input type="checkbox"/>
6	Valid practicing certificate <input type="checkbox"/> Certified <input type="checkbox"/> Not certified <input type="checkbox"/> Original certificate shown	<input type="checkbox"/>

<p>Please hand in this form with payment and required attachments and documentations to:</p>	<p>Secretariat Boards Management Office 2nd Floor, Ministry of Health Commonwealth Drive Brunei Darussalam</p> <p>..... +673 2380170 : bmo brunei@moh.gov.bn</p>
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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: - -