



BMB REGISTRATION NO.

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

How to complete this application form

- Read and **complete all questions**
- Ensure that **all pages** and required **documentations** are submitted to Brunei Medical Board Office
- 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 Widow Race: Religion:

SECTION B: Contact information

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

What are your contact details?

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.

Three horizontal text input boxes for the principal place of practice address.

Post Code

Telephone Facsimile
Type of practice: Government Private
Date of Commencement: - -
Department (if Government):

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

My residential address My principal place of practice
 Other (*provide your mailing address below*)

Post Code

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
Name of institution (University/College/Examining body)
Country
Commencement date: - - Completion date: - -

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:	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
Completion date:	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>

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"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
Completion date:	<input type="text"/> <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	<input type="text"/> <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"/> <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	<input type="text"/> <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"/> <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.

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

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

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.*

ENGLISH/MALAY LANGUAGE PROFICIENCY

a) English was the language of instruction in previous studies/employment
If not, please state language : _____

YES NO

b) Will sit/have sat for an English/Malay Proficiency Test

YES NO

Date : _____

Test name : _____

Result (if known) : _____

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.	Required documents	Attached
1	Proof documentation of offer of clinical job	<input type="checkbox"/>
2	Certified true copy of Basic Medical/Dental Degree Certificate	<input type="checkbox"/>
3	Proof documentation of post-housemanship/internship clinical experience	<input type="checkbox"/>
4	Certified true copy of Post-Graduate Qualification Certificates (if applicable)	<input type="checkbox"/>
5	Proof of Verification document of Basic Medical/Dental Degree Qualification to be sent directly to Brunei Medical Board	<input type="checkbox"/>
6	Certificate of Registration with current Medical/Dental Licensing Authority	<input type="checkbox"/>
7	Certificate/Letter of Good Standing not more than 6 months old	<input type="checkbox"/>
8	Work reference from current/last place of practice	<input type="checkbox"/>
9	Up-to-date Curriculum Vitae	<input type="checkbox"/>
10	Proof of identity (passport, or Brunei Identity Card if Brunei Citizen)	<input type="checkbox"/>
11	One (1) colour passport photo (with name written at the back)	<input type="checkbox"/>
12	Valid Medical Fitness Certificate issued or endorsed by an approved Occupational Health Practitioner in Brunei Darussalam	<input type="checkbox"/>
13	Police Clearance Certificate (from country of origin and last country of practice)	<input type="checkbox"/>
Payment		
i	Fees	
	i) Registration fee	<input type="checkbox"/>
	ii) Administrative fee	<input type="checkbox"/>

Please hand in this form completed with required documentations and payment (if applicable) to:

BRUNEI MEDICAL BOARD
Unit 2G4:02
4th Floor
Ong Sum Ping Condominium
Brunei Darussalam
BA 1311
 Email : bmb.brunei@moh.gov.bn
 Tel : +673 2237313
 Fax : +673 2237319

SECTION I: FOR OFFICE USE ONLY

Date received: - -

Payment:

1. Amount:

2. Receipt No.:

Date: - -

Processed by:

Registration approved:

Registration rejected:

Type of Registration endorsed by the Board

Full

Provisional

Conditional

Temporary

Comments:

Signature and Stamp:

Date: - -