

APPLICATION FORM

CONTINUING MEDICAL EDUCATION	ON SEPARATE SHEET, LIST ALL POSTGRADUATE ACTIVITIES WHICH YOU HAVE ATTENDED OR DURING PREVIOUS THREE YEARS (INCLUDED REPRINTS)	
	FURNISH A LIST OF SCIENTIFIC PAPERS OR ESSAYS YOU HAVE WRITTEN AND A LIST OF SCIENTIFIC MEETING YOU HAVE ATTENDED DURING PREVIOUS THREE YEARS (INCLUDED REPRINTS)	
AFFILIATION	LIST ALL PRESENT AND PREVIOUS HOSPITAL AFFILIATION AND MEDICAL STAFF MEMBERSHIPS, IN CHRONOLOGICAL ORDER (INCLUDE ASSISTANTSHIP AND APPOINTMENTS) SPECIFY ALL DEPARTMENTS IN WHICH PRIVILEGES WERE EXERCISED AND NATURE AND EXTENT OF SUCH PRIVILEGES (AFTER POST-GRADUATION)	
	HOSPITAL	
	TELEPHONE#	FAX#
	CAPACITY	DATES#
	HOSPITAL	
	TELEPHONE#	FAX#
	CAPACITY	DATES#
DESCRIPTION OF PRACTICE	ON SEPARATE SHEET, GIVE NARRATIVE SUMMARY OF ALL PAST AND PRESENT MEDICAL PRACTICE AFTER POST-GRADUATE INCLUDING OFFICE, CLINIC, HOSPITAL AND MILITARY SERVICE	
CERTIFICATION / AMERICAN BOARD / ROYAL COLLEGE / CPSP	CERTIFIED BY AMERICAN BOARD OF (NAME OF BOARD) /CPSP / ROYAL COLLEGE	DATES#
	SUBSPECIALITY BOARD STATUS (NAME OF BOARD) ARE YOU CERTIFIED?	DATES#
	IF NOT CERTIFIED, GIVE PRESENT STATUS	
LICENSING / REGISTRATION / GMC / IRISH MEDICAL COUNCIL / OTHER	MEDICAL LICENSE (P.M.D.C. REG. #)	DATES OF EXPIRING
	OTHER (NATURE OF LICENSE)	DATES LICENSE NO.
MEDICAL REFERENCES	IF POSSIBLE, INCLUDE TWO MEMBERS OF SHIFA INTERNATIONAL HOSPITAL MEDICAL STAFF, OTHER THAN THOSE WHO MIGHT BE LISTED UNDER NOTE	
	DOCTOR NAME & ADDRESS	TELEPHONE
	DOCTOR NAME & ADDRESS	TELEPHONE
	DOCTOR NAME & ADDRESS	TELEPHONE
I HEREBY APPLY TO SHIFA INTERNATIONAL HOSPITAL FOR APPOINTMENT AS	TO THE CONSULTATION / ASSOCIATE STAFF ON THE DEPARTMENT OF	
	COURTESY STAFF IN DEPARTMENT OF	
	OTHERS (SPECIFY)	
PRIVILEGES DESIRED	PLEASE FILL THE ATTACHED PRIVILEGES FORM	

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IDENTIFYING INFORMATION	LAST NAME	FIRST NAME	MIDDLE NAME
	BIRTH PLACE	DATE OF BIRTH	CITIZENSHIP
	OFFICE ADDRESS	TELEPHONE	FAX #
	HOME ADDRESS	TELEPHONE	FAX #
	PERMANENT HOME ADDRESS IN PAKISTAN	TELEPHONE	FAX #
	HOSPITAL ADDRESS	TELEPHONE	FAX #
	MARITAL STATUS	NAME OF SPOUSE	NUMBER OF CHILDREN
	SPECIALITY	SUBSPECIALITY	
	E-MAIL	MOBILE	
MEDICAL INFORMATION	ON SEPARATE SHEET, FURNISH DATE OF LAST PHYSICAL EXAMINATION, SIGNIFICANT FINDINGS, NAME OF PHYSICIAN AND/OR INSTITUTION WHERE PERFORMED, AND DATES AND CAUSES OF ALL HOSPITALIZATIONS FOR PAST FIVE YEARS		
PREMEDICAL INFORMATION	COLLEGE OR UNIVERSITY		DEGREE
	ADDRESS		DATE OF GRADUATION
MEDICAL EDUCATION			DEGREE
			DATE OF GRADUATION
HOUSE JOB	HOSPITAL	ADDRESS	
	TYPE OF TRAINING	DATES	
	HOSPITAL	ADDRESS	
	TYPE OF TRAINING	DATES	
INTERNSHIP/ SHO	HOSPITAL	ADDRESS	
	TYPE OF TRAINING	DATES	
	HOSPITAL	ADDRESS	
	TYPE OF TRAINING	DATES	
RESIDENCES/ REGISTRAR	HOSPITAL	ADDRESS	
	TYPE OF TRAINING	DATES	
	HOSPITAL	ADDRESS	
	TYPE OF TRAINING	DATES	
FELLOWSHIP/ SUBSPECIALITY	HOSPITAL	ADDRESS	
	TYPE OF TRAINING	DATES	
	HOSPITAL	ADDRESS	
	TYPE OF TRAINING	DATES	