حكومة دبي
GOVERNMENT OF DUBAI

سلطة مدينة دبي الطبية
DUBAI HEALTHCARE CITY AUTHORITY

Application for Certification

Exclusive licensure for practicing in Dubai Healthcare City

☐ **Operator sponsoring application (indicate name):** ____
If you tick the above box please attach Letter of Intent/Offer Letter from the clinical facility

☐ **No operator (Please notify "Licensing Department when you start work at DHCC)**
Please seek information on Letter of Acceptance (LOA)

Please check box that applies:

☐ Nursing Assistant
☐ Dental Assistant

ALL FIELDS ARE MANDATORY

Please type or print clearly in ENGLISH LANGUAGE

1. Name: *Please enter your complete name and any maiden/previous name as per passport.*

FIRST AND MIDDLE NAME(S): ____

MAIDEN NAME(S): ____

PREVIOUS NAME(S): ____

2. Contact Information: *Please provide ONE mailing address only.*

STREET ADDRESS/POST OFFICE BOX: ____

____

CITY: ______________________ STATE/PROVINCE: ______________________

COUNTRY: ______________________ POSTAL/ZIP CODE: ______________________

TELEPHONE NUMBER: ______________________ MOBILE NUMBER: ______________________

FACSIMILE NUMBER: ______________________ E-MAIL ADDRESS 1: ______________________

E-MAIL ADDRESS 2: ______________________

3. Date and Place of Birth: *Please enter your date and place of birth.*

DAY: ____________ MONTH: ______________ YEAR: ____________

COUNTRY OF BIRTH: ______________________ CURR|ENT NATIONALITY/ CITIZENSHIP: ______________________

4. Gender: *Please check one.*

☐ MALE ☐ FEMALE

CPQ. All rights reserved.

5. Identification Details: Please fill in the details.

PASSPORT NUMBER: ____________________ COUNTRY OF ISSUE: __________________________EXPIRY DATE: ______________________

UAE ID CARD NO. : ____________________ EXPIRY DATE: ______________________

6. Have you ever applied for a Nursing License to Practice in DHCC? YES ☐ NO ☐

IF YES, PLEASE LIST DHCC LICENSE NUMBER/LOA OR ATTACH COPY: ____

7. Languages Spoken: Please fill in the details.

☐ ARABIC ☐ ENGLISH OTHERS: _______________________________ ___________________________________

8. Language Proficiency

WAS ENGLISH THE LANGUAGE OF INSTRUCTION FOR YOUR EDUCATION PROGRAM? ☐ YES ☐ NO

IF NO, WHAT WAS THE LANGUAGE OF INSTRUCTION? ____

IF ENGLISH WAS NOT THE LANGUAGE OF INSTRUCTION OF YOUR EDUCATION, HAVE YOU EVER TAKEN THE ENGLISH PROFICIENCY TEST?

☐ YES ☐ NO

IF YOU HAVE TAKEN THE ENGLISH PROFICIENCY TEST,

SCORE: _________________________________. PLEASE ATTACH COPY OF ENGLISH PROFICIENCY TEST RESULT
Please refer to the Healthcare Professionals Regulation under Schedule Two for details on English proficiency requirements

9. College/University: Please list all university/schools attended not just the one from which you graduated.

FULL NAME OF COLLEGE/UNIVERSITY: ____

STREET ADDRESS/POST OFFICE BOX, CITY: ____

STATE/PROVINCE: _____________________COUNTRY:______________________ POSTAL/ZIP CODE: _____________________________

TELEPHONE NUMBER: ___________________________________ FACSIMILE NUMBER: ____

EMAIL ADDRESS: _______________________________________WEBSITE ADDRESS: ____
Please provide official email address; personal email address will not be accepted.

ATTENDED FROM (DD/MM/YYYY): _______________________________ TO (DD/MM/YYYY): __________________________________

GRADUATION DATE (DD/MM/YYYY): _________________________________

DEGREE/QUALIFICATION OBTAINED (e.g. B.Sc, B.A): ____

Other University(s)/School(s) Attended

FULL NAME OF COLLEGE/UNIVERSITY: ____

STREET ADDRESS/POST OFFICE BOX, CITY: ____

STATE/PROVINCE: _____________________COUNTRY:______________________ POSTAL/ZIP CODE: _____________________________

TELEPHONE NUMBER: ___________________________________ FACSIMILE NUMBER: ____

EMAIL ADDRESS: _______________________________________WEBSITE ADDRESS: ____
Please provide official email address; personal email address will not be accepted.

ATTENDED FROM (DD/MM/YYYY): _______________________________ TO (DD/MM/YYYY): __________________________________

GRADUATION DATE (DD/MM/YYYY): _________________________________

DEGREE/QUALIFICATION OBTAINED (e.g. B.Sc, B.A): ____
If additional sheet(s) are required for listing other College/University, please attach

CPQ. All rights reserved.

10. Diplomas/Certificates Awarded: *Please provide a summary of your diplomas/certificates obtained since completion of your education.*

LIST ALL DIPLOMAS/CERTIFICATES THAT HAVE BEEN OBTAINED IN YOUR AREA OF WORK:

DIPLOMA/CERTIFICATE AWARDED	COUNTRY	ID #	DATE OF ISSUE	DATE OF EXPIRY

11. Continuing Education

HAVE YOU ATTENDED CONTINUING EDUCATION (CLASSES, CONFERENCES, COURSES, AND SEMINARS) IN THE PAST THREE YEARS?

☐ YES ☐ NO

IF "YES" HOW MANY TOTAL HOURS OVER THE LAST THREE YEAR PERIOD HAVE YOU OBTAINED? ________________________________

12. Work Experience: *Please provide a summary of your professional practice for at least the last ten (10) years (if applicable).*

APPOINTMENT/POSITION/TITLE	NAME AND ADDRESS OF INSTITUTE OF PRACTICE	CLINICAL DEPARTMENT/AREA OF PRACTICE	FROM (DD/MM/YYYY)	TO (DD/MM/YYYY)

CPQ. All rights reserved.

***13. Additional Questions**: Please answer the following questions.*

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL CHARGE?

☐ YES ☐ NO

DO YOU SUFFER, OR HAVE YOU SUFFERED IN THE PAST, ANY PHYSICAL OR MENTAL DISABILITY THAT MAY IMPAIR YOUR ABILITY TO WORK?

☐ YES ☐ NO

WITHIN THE PAST TWO (2) YEARS, HAVE YOU ENGAGED IN THE USE OF CHEMICAL SUBSTANCES WITH THE RESULT THAT YOUR ABILITY TO WORK IS CURRENTLY IMPAIRED OR LIMITED?

☐ YES ☐ NO

HAVE YOU EVER REFUSED TO SUBMIT TO A TEST TO DETERMINE WHETHER YOU HAD CONSUMED AND/OR WERE UNDER THE INFLUENCE OF CHEMICAL SUBSTANCES?

☐ YES ☐ NO

All information will be subject to DHCC Laws of Confidentiality.

CPQ. All rights reserved.

14. Documentation Checklist: Please submit the following.

☐ COMPLETED APPLICATION (All applicable information's should be completed in ENGLISH)

☐ TWO (2) PASSPORT-SIZED PHOTOS

☐ **ONE (1) COPY EACH**, INCLUDING CERTIFIED ENGLISH TRANSLATIONS IF ORIGINAL DOCUMENTS ARE NOT IN ENGLISH, OF:

- PASSPORT (to include image, signature and number)
- HIGH SCHOOL DIPLOMA
- CERTIFICATES/DIPLOMAS FROM YOUR PROGRAM OF STUDY
- SCHOOL TRANSCRIPTS FROM YOUR PROGRAM OF STUDY
- IF APPLICABLE
  - CONTINUING EDUCATION DOCUMENTS -
  - BLS/ACLS CERTIFICATES

NOTE: *ALL EDUCATIONAL DOCUMENTS MUST BE VERIFIED AND AUTHENTICATED BY THE ISSUING UNIVERSITY/COLLEGE/SCHOOL.*

☐ CURRICULUM VITAE

☐ TWO LETTERS OF RECOMMENDATION, ONE EACH FROM A PROFESSIONAL COLLEAGUE WHO HAS WORKED WITH YOU IN THE PAST FIVE (5) YEARS.

☐ OFFICIAL EMPLOYMENT LETTER FOR THE LAST FIVE (5) YEARS.

☐ APPLICATION FEES (once submitted, fees will NOT be refundable for any reason).

☐ TOEFL/IELTS EXAM RESULTS (if applicable)

CPQ. All rights reserved.

NOTES TO CONSIDER:

- ***YOU ARE REQUIRED TO SUBMIT A COPY OF YOUR BASIC LIFE SUPPORT (BLS) AS A MINIMUM TO COMMEMCE PRACTICE AFTER APPROVAL. HEALTHCARE PROFESSIONALS SUCH AS ANESTHESIOLOGISTS, PARAMEDICS, ETC ARE REQUIRED TO HAVE CERTIFICATION IN ACLS AS A MINIMUM.***

- ***APPLICANTS ARE REQUIRED TO IMMEDIATELY NOTIFY PROFESSIONAL LICENSING DEPARTMENT, CENTER FOR HEALTHCARE PLANNING AND QUALITY (CPQ) OF ANY CHANGES OR NEW INFORMATION RELATED TO THE APPLICATION.***

- ***ALL MATERIALS SENT AS PART OF THIS APPLICATION PROCESS WILL BE RETAINED BY CPQ LICENSING DEPARTMENT AND WILL NOT BE RETURNED TO THE APPLICANT.***

  UPON REVIEW OF THIS APPLICATION, AN INTERVIEW MAY BE REQUESTED. IN ADDITION, CPQ LICENSING DEPARTMENT RESERVES THE RIGHT TO ACCEPT OR DENY ANY APPLICANT FOR DHCC LICENSURE AT ITS SOLE DISCRETION.

ACKNOWLEDGEMENT:

- ***I HEREBY CONFIRM THAT THE ABOVE INFORMATION IS TRUTHFUL AND AUTHORIZE CPQ LICENSING DEPARTMENT TO CONTACT MY UNIVERSITIES, HOSPITALS, TRAINING PROGRAMS, AND REFERENCES FOR PURPOSES OF PRIMARY SOURCE VERIFICATION.***

- ***PLEASE NOTE BY SIGNING THIS FORM "I ACKNOWLEDGE THAT INFORMATION ABOUT ME RELEVANT TO MY PRACTICE MAY BE MADE PUBLIC; I AM AWARE OF THE REQUIREMENT ON ME TO REPORT TO THE COMPLAINT UNIT ANY HEALTHCARE PROFESSIONAL WHO IS IMPAIRED OR DISABLED FOR WHATEVER REASON AND WHO'S IMPAIRMENT CONSTITUTES A PUBLIC RISK."***

____
Applicant's Signature (must be signed in the presence of a notary public, consular official, or first class magistrate)

____
Applicant's printed last name, first name, middle initial, suffix (e.g., Jr.)

____
Date of signature (DD/MM/YYYY)
Date must correspond to the date of notarization

Attach one current full-face photo here. Use tape or glue; no staples, please.

Sign across the bottom or top of the photo. Do not sign at the back.

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this individual by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the individual and with the photograph affixed hereto, and (b) comparing the individual's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn before me by the individual on this _________ day, in the month of ________________, in the year ________________

X
____
Signature of Consular Official, First Class Magistrate, Notary Public (in Latin characters with English translations, where applicable.)

____
Official Title

CPQ. All rights reserved.

Submission of Completed Application

Please request for an appointment with the Licensing Department to assess eligibility for licensure and completeness of your application by sending an email to info@cpq.dhcc.ae .

If you are not available to meet, please send via courier the completed application to the below address:

Licensing Department
Centre for Healthcare Planning and Quality (CPQ)
Ibn Sina Building, Block B, Ground Floor
Dubai Healthcare City
Oud Metha Road
Dubai, United Arab Emirates
Tel: +971-4-362-2790, Fax: +971-4-362-4770

The Licensing Department contact details are listed below:

Licensing Department
Centre for Healthcare Planning and Quality (CPQ)
Dubai Healthcare City
P.O. Box 505001
Dubai, United Arab Emirates
Tel: +971-4-362-2790, Fax: +971-4-362-4770

CPQ. All rights reserved.