



Application for Doctor of Complementary & Alternative Medicine (CAM) License

Exclusive licensure for practicing in Dubai Healthcare City.

Operator sponsoring application (indicate name): _____

No operator (Please notify Licensing Department when you start working at DHCC)
Please see "Letter of Acceptance" information.

Please check box that applies:

- | | | | |
|---------------------------------------|--------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Ayurveda | <input type="checkbox"/> Naturopathy | <input type="checkbox"/> Traditional Chinese Medicine | <input type="checkbox"/> Unani |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Osteopathy | | |
| <input type="checkbox"/> Homeopathy | | | |

Please type or print clearly IN ENGLISH LANGUAGE.

1. Name Enter your complete name and any maiden/previous name.

LAST NAME: _____
FIRST AND MIDDLE NAME(S): _____
MAIDEN NAME(S): _____
PREVIOUS NAME(S): _____

2. Contact Information 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: _____

3. Date and Place of Birth Enter your date and place of birth.

DAY: _____ MONTH: _____ YEAR: _____
COUNTRY OF BIRTH: _____ NATIONALITY/ CITIZENSHIP: _____

4. Gender Please check one

MALE FEMALE

5. Identification Numbers Enter all identification numbers.

SOCIAL SECURITY, NATIONAL, OR CIVIL ID NUMBER (IF APPLICABLE): _____

PASSPORT NUMBER: _____ COUNTRY OF ISSUE: _____

6. License/Registration List all jurisdictions in which a license to practice has been obtained. Include permanent, limited, and other special purpose licenses or registrations.

HAVE YOU EVER APPLIED FOR A CAM PROFESSIONAL LICENSE TO PRACTICE IN DHCC? YES NO

If yes, please list DHCC License Number: _____

DO YOU REQUIRE A LICENSE/REGISTRATION OR CERTIFICATE TO PRACTICE IN THE COUNTRY WHERE YOUR QUALIFICATION WAS OBTAINED? YES NO

DO YOU HAVE A CURRENT LICENSE/REGISTRATION? YES NO

FULL NAME OF LICENSING/REGISTRATION JURISDICTION: _____

STREET ADDRESS/POST OFFICE BOX: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

LICENSE/REGISTRATION NUMBER: _____

LICENSE ISSUE DATE (MM/YY): _____ LICENSE EXPIRATION DATE (MM/YY): _____

LICENSE REGISTRATION STATUS (CHECK ONE):

ACTIVE INACTIVE SUSPENDED REVOKED

If the license is suspended or revoked, please attach a separate sheet of paper with an explanation.

Other Jurisdictions Where a License/Registration Was Obtained (if applicable)

FULL NAME OF LICENSING/REGISTRATION JURISDICTION: _____

STREET ADDRESS/POST OFFICE BOX: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

LICENSE/REGISTRATION NUMBER: _____

LICENSE ISSUE DATE (MM/YY): _____ LICENSE EXPIRATION DATE (MM/YY): _____

LICENSE REGISTRATION STATUS (CHECK ONE):

ACTIVE INACTIVE SUSPENDED REVOKED

If the license is suspended or revoked, please attach a separate sheet of paper with an explanation. If additional sheet(s) listing other jurisdictions are enclosed, please check:

ADDITIONAL SHEET(S) ENCLOSED

7. Language Proficiency Language of your CAM education.

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

IF NO, WHAT WAS THE LANGUAGE OF INSTRUCTION? _____

IF ENGLISH WAS NOT THE LANGUAGE OF INSTRUCTION OF YOUR CAM PROGRAM, HAVE YOU EVER TAKEN THE TOEFL EXAM?

YES NO

IF YOU HAVE TAKEN THE TOEFL EXAM,

WHEN: _____ WHERE: _____ SCORE: _____

ORGANIZATION/INSTITUTE WHO ADMINISTERED THE EXAM: _____

8. Secondary Schooling

THIS SECTION MUST BE COMPLETED BY THOSE APPLICANTS WHO HAVE NOT OBTAINED A BACHELOR DEGREE IN THEIR RESPECTIVE CAM PROFESSION.

NAME OF SECONDARY SCHOOL: _____

DATE OF GRADUATION FROM SECONDARY SCHOOL (MM/YY): _____

9. CAM School/Universities

List all CAM schools attended, not just the one from which you graduated. If you attended more than two schools, list the additional schools on a photocopy page of this section.

FULL NAME OF UNIVERSITY/SCHOOL: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

ATTENDED FROM (DD/MM/YY): _____ TO (DD/MM/YY): _____

GRADUATION DATE (MM/YY): _____ DEGREE OBTAINED: _____

NAME AT GRADUATION DATE: _____

Other Universities/School(s) Attended

List other degrees (e.g. diplomas, BSc, master etc.....) related to healthcare field.

FULL NAME OF UNIVERSITY/SCHOOL: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

ATTENDED FROM (DD/MM/YY): _____ TO (DD/MM/YY): _____

GRADUATION DATE (MM/YY): _____ DEGREE OBTAINED: _____

NAME AT GRADUATION DATE: _____

If additional sheet(s) listing other universities/schools attended are enclosed, please check:

ADDITIONAL SHEET(S) ENCLOSED

10. Postgraduate Education List other healthcare related postgraduate specialties/courses obtained after graduation from university/school.

FULL NAME OF UNIVERSITY/SCHOOL: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

ATTENDED FROM (DD/MM/YY): _____ TO (DD/MM/YY): _____

GRADUATION DATE (MM/YY): _____

If additional sheet(s) listing other universities/schools attended are enclosed, please check:

ADDITIONAL SHEET(S) ENCLOSED

11. Professional Memberships/Affiliations

FULL NAME OF INSTITUTION: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

MEMBERSHIP/AFFILIATION FROM (MM/YY) _____ TO (MM/YY): _____

Other Institution(s)

FULL NAME OF INSTITUTION: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

MEMBERSHIP/AFFILIATION FROM (MM/YY): _____ TO (MM/YY): _____

ADDITIONAL SHEET(S) ENCLOSED

12. Work Experience Please provide a summary of your professional practice from the last ten (10) years.

APPOINTMENT GRADE AND TITLE	NAME AND ADDRESS FOR INSTITUTION OF PRACTICE	AREA OF PRACTICE	FROM (M/Y)	TO (M/Y)

13. Are you certified by any board, college or association in a specific clinical area? YES NO

FULL NAME OF BOARD/COLLEGE/ASSOCIATION: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

DATE CERTIFICATION OBTAINED: _____

BOARD/COLLEGE/ASSOCIATION IDENTIFICATION NUMBER: _____

ADDITIONAL SHEET(S) ENCLOSED

14. Additional Questions Please answer the following additional questions.

HAVE YOU EVER BEEN SUED OR BEEN INVOLVED IN ANY MALPRACTICE OR MEDICAL NEGLIGENCE LITIGATION IN THE LAST TEN (10) YEARS?

YES NO

DO YOU CARRY MALPRACTICE INSURANCE?

YES NO

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 PRACTICE MEDICINE?

YES NO

HAS ANY DISCIPLINARY ACTION EVER BEEN TAKEN AGAINST YOU FOR VIOLATION OF LAWS, RULES, BY-LAWS, OR STANDARDS OF PRACTICE BY ANY GOVERNMENT AUTHORITY, HEALTHCARE FACILITY, GROUP PROFESSIONAL MEDICAL SOCIETY OR ASSOCIATION IN ANY JURISDICTION?

YES NO

WITHIN THE PAST TWO (2) YEARS, HAVE YOU ENGAGED IN THE USE OF CHEMICAL SUBSTANCES WITH THE RESULT THAT YOUR ABILITY TO PRACTICE MEDICINE 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.

*** If the answer is YES to any of the above questions, please attach a typewritten explanation sheet to this application.**

ARE YOU CERTIFIED IN BASIC LIFE SUPPORT (BLS)

YES NO (If yes, please provide a copy)

ARE YOU CERTIFIED IN ADVANCED CARDIAC LIFE SUPPORT (ACLS)?

YES NO (If yes, please provide a copy)

ARE YOU CERTIFIED IN CARDIO-PULMONARY RESUSITATION (CPR)?

YES NO (If yes, please provide a copy)

IF YOUR RESPONSES TO ANY OF THE ABOVE QUESTIONS CHANGE, YOU MUST IMMEDIATELY NOTIFY THE CENTER FOR HEALTHCARE PLANNING AND QUALITY (CPQ) OF THE NEW INFORMATION.

15. Documentation Please provide the following:

- COMPLETED APPLICATION (All applicable information's should be completed in ENGLISH)
- TWO (2) PASSPORT-SIZED PHOTOS
- SIGNED CCSI AFFIDAVIT AND RELEASE FORMS
- TWO (2) COPIES EACH, INCLUDING CERTIFIED ENGLISH TRANSLATIONS IF ORIGINAL DOCUMENTS ARE NOT IN ENGLISH, OF:**
- PASSPORT (to include image, signature and number)
 - CAM LICENSE/REGISTRATION (authenticated copy is required)
 - CAM DEGREES/DIPLOMA (authenticated copy is required)
 - SCHOOL TRANSCRIPTS FROM YOUR CAM PROGRAM OF STUDY
 - IF APPLICABLE
 - POSTGRADUATE DEGREES/DIPLOMAS/CERTIFICATES (authenticated copy(s) is required)
 - BOARD/COLLEGE/ASSOCIATION CERTIFICATES (authenticated copy(s) is required)
 - BLS/ACLS CERTIFICATES
 - CAM MALPRACTICE INSURANCE POLICY (U.A.E. COVERAGE ONLY)

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. ONE OF THE LETTERS MUST BE WRITTEN BY A COLLEAGUE WHO IS EMPLOYED IN A SUPERVISOR CAPACITY (EXCLUDING RELATIVES). THESE REFERENCES SHOULD ADDRESS MORAL AND ETHICAL CHARACTER AND COMPETENCIES TO PRACTICE HEALTHCARE.
- OFFICIAL EMPLOYMENT LETTER FOR THE LAST FIVE (5) YEARS.
- APPLICATION FEES (once submitted, fees will NOT be refundable for any reason).
- TOEFL EXAM RESULTS (if applicable)

Please note:

All materials sent as part of this application process will be retained by the CPQ Licensing Department and will not be returned to the applicant.

Upon review of this application, an interview may be requested. In addition, the CPQ Licensing Department reserves the right to accept or deny any applicant for licensure at its sole discretion.

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 certain information in this application may be made public as per CPQ licensing regulations; 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 whose impairment constitutes a public risk."

 Signature

 Date (Day/Month/Year)

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make on or in connection with the application are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies I furnish with my application are true and correct.

I acknowledge that I have read and understand the “Application for Complementary & Alternative Medicine (CAM) Practitioner License” and have answered all questions contained in the application truthfully and completely.

I authorize every person, school, university, hospital, clinic, government agency, or institution having custody or control of any documents, records, and other information pertaining to me to furnish to Custom Credentialing Service, Inc. (CCSI) any such information, or true and correct copies of documents or records.

I hereby release, discharge, and hold harmless Custom Credentialing Service, Inc. (CCSI), its employees, agents, or representatives, and any person furnishing information, records, or documents of any and all liability. I authorize the Custom Credentialing Service, Inc. (CCSI) to release information, material, documents, orders, or the like relating to me or this application to Center for Healthcare Planning and Quality.

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 (must correspond to date of notarization)

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

Sign across the bottom or top of the photo do not sign 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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, the undersigned, hereby authorize Custom Credentialing Services, Inc. (CCSI) to collect, verify, and maintain information and copies of documents and records in support of my Application for Complementary & Alternative Medicine (CAM) Practitioner License, for practice in Dubai Healthcare City.

I request and authorize every person, school, university, institution, professional licensing board, hospital, clinic, insurance company, government agency, or other third parties and organizations and their representatives to release information, records, diplomas, transcripts, and other documents concerning my professional education, qualifications, experience and competence, ethics, character, practice claim history, and other information pertaining to me to Custom Credentialing Services, Inc. (CCSI).

I further request and authorize that the requested information, records, diplomas, transcripts, and other documents be sent directly to Custom Credentialing Service, Inc (CCSI).

Immunity and Release

I hereby extend absolute immunity to, and release, discharge, and hold harmless from any and all liability: (1) Custom Credentialing Services, Inc. (CCSI) its employees, agents, representatives, directors, and officers; (2) other agencies, health schools, universities, institutions, hospitals, and clinics providing information, their employees, representatives, directors, and officers; and (3) any third parties and organizations for any acts, communications, reports, records, diplomas, transcripts, statements, documents, recommendations, or disclosures involving me, made in good faith and without malice, requested and received by the Custom Credentialing Services, Inc.(CCSI). I understand that Custom Credentialing Services, Inc. (CCSI) will not accept such information, records, or documents forwarded by me.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid from the date signed.

Signature

Date of signature

Printed last name, first name, middle initial, suffix (e.g., Jr.)

Date of birth (day, month, year)

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

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

16. Mailing Addresses

Please mail your completed application to:

Licensing Department
Centre for Planning and Quality
Dubai Healthcare City
P.O. Box 66566
Dubai
United Arab Emirates
Tel: +971-4-362-2790
Fax: +971-4-362-4770

For courier delivery:

Licensing Department
Centre for Planning and Quality
The 4 Buildings, Block B
Dubai Healthcare City
Oud Metha Road
Dubai
United Arab Emirates
Tel: +971-4-362-2790
Fax: +971-4-362-4770