



Application for Doctor of Medicine with a Complementary and Alternative Medicine (CAM) Specialty

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:

General Medical License Medical Specialty License Specialty applied for: _____

Please fill in part 1 which is specifically Conventional Medicine information

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. Medical 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 PHYSICIAN LICENSE TO PRACTICE IN DHCC? YES NO

If yes, please list DHCC License Number: _____

FULL NAME OF LICENSING/REGISTRATION JURISDICTION: _____

STREET ADDRESS/POST OFFICE BOX: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

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

LICENSE/REGISTRATION NUMBER: _____

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

LICENSE/REGISTRATION NUMBER: _____

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. Medical School List all medical 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: _____

Other University(s)/School(s) Attended

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 (DDMM/YY): _____ TO (DD/MM/YY): _____
GRADUATION DATE (MM/YY): _____
DEGREE OBTAINED: _____

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

ADDITIONAL SHEET(S) ENCLOSED

8. Postgraduate Education

List all other postgraduate medical education obtained after graduation from university/school.

PLEASE DESCRIBE YOUR SPECIALTY TRAINING PROGRAM: _____

FULL NAME OF INSTITUTE: _____
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): _____
COMPLETED: YES NO COMPLETION DATE (MM/YY): _____
DEGREE/CERTIFICATE OBTAINED: _____

Other Postgraduate Medical Education

PLEASE DESCRIBE YOUR SPECIALTY TRAINING PROGRAM: _____

FULL NAME OF INSTITUTE: _____

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): _____

COMPLETED: YES NO COMPLETION DATE (MM/YY): _____

DEGREE/ CERTIFICATE OBTAINED: _____

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

ADDITIONAL SHEET(S) ENCLOSED

9. Board or College Certified Specialties

ARE YOU BOARD OR COLLEGE CERTIFIED IN YOUR SPECIALTY IN ANY COUNTRY?

YES NO

NAME OF BOARD/ COLLEGE: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

DATE CERTIFICATION OBTAINED (DD/MM/YY): _____

BOARD/COLLEGE IDENTIFICATION NUMBER: _____

Other Certifying Board(s) or College(s)

NAME OF BOARD/ COLLEGE: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

DATE CERTIFICATION OBTAINED (DD/MM/YY): _____

BOARD/COLLEGE IDENTIFICATION NUMBER: _____

If additional sheet(s) listing other board/college certifications are enclosed, please check:

ADDITIONAL SHEET(S) ENCLOSED

10. Professional Memberships/Affiliations *Please provide a summary of your professional membership/affiliation activities since completion of your training.*

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): _____

If additional sheet(s) listing other institutions attended are enclosed, please check:

ADDITIONAL SHEET(S) ENCLOSED

11. Work Experience Please provide a summary of your professional practice for 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)

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12. Privileges

PHYSICIANS:

Please complete a physician privileging form (available from CPQ Licensing Department or DHCC website). This does not substitute for hospital privileging.

13. Additional Questions Please answer the following questions:

SINCE YOUR ENROLLMENT IN MEDICAL SCHOOL, HAVE YOU BEEN SUBJECT TO ANY DISCIPLINARY ACTION AT AN ACADEMIC INSTITUTION?

- YES NO

SINCE YOUR ENROLLMENT IN MEDICAL SCHOOL, HAVE YOU BEEN DENIED THE PRIVILEGE OF TAKING OR FINISHING AN EXAMINATION OR BEEN ACCUSED OF CHEATING AND/OR IMPROPER CONDUCT DURING AN EXAMINATION?

- YES NO

HAVE YOU BEEN TERMINATED OR GRANTED A LEAVE OF ABSENCE BY A MEDICAL SCHOOL OR MEDICAL POST-GRADUATE TRAINING PROGRAM OR HAVE YOU EVER WITHDRAWN FROM A MEDICAL SCHOOL OR MEDICAL POSTGRADUATE TRAINING PROGRAM OR HAD TO REPEAT A YEAR OF POSTGRADUATE TRAINING?

- YES NO

HAVE YOU EVER APPLIED FOR LICENSURE OR TO SIT FOR AN EXAMINATION OR TAKEN AN EXAMINATION UNDER A DIFFERENT NAME? IF YES; THEN LIST ALL PREVIOUS NAMES AND OCCASION ON WHICH THEY WERE USED?

- YES NO

DO YOU CARRY MEDICAL MALPRACTICE INSURANCE?

- YES NO

If yes, please include a copy of your medical malpractice insurance policy.

DO YOU POSSESS A SPECIFIC LICENSE TO PRESCRIBE NARCOTIC MEDICATION, E.G. A UNITED STATES DEA LICENSE?

- YES NO

HAVE YOU EVER, FOR ANY REASON, BEEN DENIED A MEDICAL LICENSE, WHETHER FULL, LIMITED, TEMPORARY, OR HAVE YOU WITHDRAWN AN APPLICATION FOR MEDICAL LICENSURE?

- YES NO

HAVE YOU EVER VOLUNTARILY SURRENDERED A LICENSE TO PRACTICE MEDICINE?

- YES NO

HAVE YOU EVER, FOR ANY REASON, LOST OR BEEN DENIED REQUIRED RE-CERTIFICATION BY ANY SPECIALTY BOARDS OR COLLEGE IN ANY JURISDICTION?

- YES NO

ARE ANY FORMAL DISCIPLINARY CHARGES PENDING AGAINST YOU, OR DO YOU HAVE KNOWLEDGE OF ANY PENDING INVESTIGATION INTO YOUR PROFESSIONAL COMPETENCE OR CONDUCT BY ANY GOVERNMENTAL AUTHORITY, HEALTH CARE FACILITY, GROUP PRACTICE OR PROFESSIONAL MEDICAL SOCIETY OR ASSOCIATION IN ANY JURISDICTION?

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 OR PROFESSIONAL MEDICAL SOCIETY OR ASSOCIATION IN ANY JURISDICTION?

YES NO

HAS YOUR MEDICAL STAFF MEMBERSHIP, MEDICAL PRIVILEGES OR MEDICAL STAFF STATUS IN ANY HOSPITAL, CLINIC, OR OTHER SUCH FACILITY IN ANY JURISDICTION BEEN LIMITED, SUSPENDED, REVOKED, NOT RENEWED OR SUBJECT TO PROBATIONARY CONDITIONS OR IS PROCESSING TOWARDS ANY OF THOSE ENDS BEEN INSTITUTED OR RECOMMENDED BY A MEDICAL STAFF COMMITTEE OR GOVERNING BOARD?

YES NO

HAVE YOU EVER BEEN CHARGED WITH ANY CRIMINAL OFFENSE, OTHER THAN A MINOR TRAFFIC OFFENSE, IN ANY JURISDICTION?

YES NO

IN THE PAST (10) YEARS, HAS ANY MEDICAL MALPRACTICE CLAIM BEEN MADE AGAINST YOU IN ANY JURISDICTION, WHETHER OR NOT A LAWSUIT WAS FILED IN RELATION TO THE CLAIM?

YES NO

IN THE LAST (10) YEARS, HAS ANY LAWSUIT, OTHER THAN A MEDICAL MALPRACTICE SUIT, WHICH IS RELATED TO YOUR COMPETENCY TO PRACTICE MEDICINE, OR YOUR PROFESSIONAL CONDUCT IN THE PRACTICE OF MEDICINE, BEEN FILED AGAINST YOU OR HAS SUCH A SUIT BEEN SETTLED, ADJUDICATED OR OTHERWISE RESOLVED?

YES NO

SINCE BECOMING A MEDICAL STUDENT, HAVE YOU BEEN DIAGNOSED WITH OR TREATED FOR A MEDICAL CONDITION THAT IN ANY WAY CURRENTLY LIMITS OR IMPAIRS YOUR ABILITY TO PRACTICE MEDICINE OR TO FUNCTION AS A PHYSICIAN?

YES NO

DO YOU CURRENTLY HAVE A MEDICAL CONDITION THAT IN ANY WAY LIMITS OR IMPAIRS YOUR ABILITY TO PRACTICE MEDICINE OR TO FUNCTION AS A PHYSICIAN?

YES NO

WITHIN THE PAST TWO 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

ARE YOU CURRENTLY ENGAGED IN THE ILLEGAL USE OF DRUGS OR MISUSE OF PRESCRIPTION DRUGS?

YES NO

HAVE YOU EVER BEEN ACCUSED OF FRAUDULENT MEDICAL PRACTICE OR FRAUDULENT MEDICAL BILLING PRACTICES?

YES NO

HAVE YOUR PRIVILEGES TO PRESCRIBE NARCOTICS EVER BEEN REVOKED?

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)

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.

14. Documentation Please return the following:

- COMPLETED APPLICATION (All applicable information's should be completed in ENGLISH)
- COMPLETED PHYSICIAN PRIVILEGING FORM
- TWO (2) PASSPORT-SIZED PHOTOS
- COMPLETED ECIS AFFIDAVIT AND RELEASE FORMS FOR **PHYSICIANS**
- TWO (2) COPIES EACH, INCLUDING CERTIFIED ENGLISH TRANSLATIONS IF ORIGINAL DOCUMENTS ARE NOT IN ENGLISH, OF:**
 - MEDICAL SCHOOL TRANSCRIPTS
 - DEGREES/DIPLOMAS/CERTIFICATES (authenticated copy(s) is required)
 - BOARD/ COLLEGE CERTIFICATES (authenticated copy(s) is required)
 - MEDICAL LICENSE(S)/REGISTRATION(S) (authenticated copy(s) is required)
 - PASSPORT (INLCUDING IMAGE, SIGNATURE AND NUMBER)
 - MEDICAL MALPRACTICE INSURANCE POLICY (U.A.E. COVERAGE ONLY)
- CURRICULUM VITAE – To include chronological account (month/year) of your professional career.
- TWO LETTERS OF RECOMMENDATION, ONE EACH FROM A PROFESSIONAL COLLEAGUE (EXCLUDING RELATIVES) WHO HAS WORKED WITH YOU IN THE PAST FIVE (5) YEARS. THESE RECOMMENDATIONS SHOULD INCLUDE A STATEMENT OF MORAL AND ETHICAL CHARACTER, AND COMPETENCY TO PRACTICE MEDICINE.
- OFFICIAL EMPLOYMENT LETTER FOR THE LAST FIVE (5) YEARS.
- APPLICATION FEES (once submitted, fees will NOT be refundable for any reason).

ADDITIONAL DOCUMENTATION FOR APPLICANTS SEEKING LICENSURE VIA Option Two of “GUIDELINES FOR PHYSICIAN LICENSURE WITHIN DHCC”:

- 2 AFFIDAVIT LETTERS (attached) Page 13
- PROOF OF FIFTY (50) HOURS OF ACCREDITED CONTINUOUS MEDICAL EDUCATION (CME) OBTAINED WITHIN THE IMMEDIATE PAST TWO (2) YEARS
- EXAM RESULTS FROM APPROVED EXAM LIST

Please note:

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.

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 physician who is impaired or disabled for whatever reason and whose impairment constitutes a public risk.”

Signature

Date (Day/Month/Year)

Application for Doctor of Medicine with a Complementary and Alternative Medicine (CAM) Specialty

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"/> Tai-Chi | <input type="checkbox"/> Unani |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Osteopathy | <input type="checkbox"/> Traditional Chinese Medicine | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Guided Imagery | <input type="checkbox"/> Pilates | <input type="checkbox"/> Acupuncture | |
| <input type="checkbox"/> Homeopathy | | <input type="checkbox"/> Therapeutic Massage | |

Please fill in part 2 which is specifically CAM information
Please type or print clearly IN ENGLISH LANGUAGE.

1. 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

2. 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: _____

3. 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

4. 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

5. 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

6. 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)

7. 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

8. 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.**

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.

9. Documentation Please provide the following:

- COMPLETED APPLICATION (All applicable information's should be completed in ENGLISH)
- 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
 - MEDICAL 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).

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 a Medical Doctor of Complementary & Alternative Medicine (CAM) 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 a Medical Doctor of Complementary & Alternative Medicine (CAM) 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.

EICS

THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES INTERNATIONAL CREDENTIALS SERVICES

As part of the Application for Professional License to Practice in Dubai Healthcare City (DHCC), certain credentials must be verified for authenticity. These credentials include medical school degrees/diplomas, medical school transcripts, medical license/registration certificates in other jurisdictions, and postgraduate training certificates. The Educational Commission for Foreign Medical Graduates International Credentials Services (EICS) will obtain primary source verification of the authenticity of these documents from the entity that issued them.

DHCC will submit copies of your application and your documents to EICS to be verified. DHCC will be notified when EICS has received and processed your completed application and documentation. EICS will write to the issuing institutions listed on your application to secure primary source verification of your submitted credentials. EICS will send the institutions a copy of the document to be verified, an official EICS verification request form, and a photograph signed by you to assist in identification. EICS will request that an authorized institution official complete the verification request form and return it directly to EICS. If EICS does not receive verification of a document within sixty (60) days of the EICS request, EICS will notify DHCC regarding the documents that have not yet been verified. EICS will make a second request for verification of these documents. If EICS does not receive the confirmation form for a document within four (4) months of the initial request, EICS will notify DHCC regarding any documents they have been unable to verify.

After verification of all the required credentials has been secured, an EICS report will be sent to DHCC. The report will contain your name and biographic information and a list of the medical credentials that were verified. The EICS report will also include copies of the credentials that were verified.

In order to begin this process, the EICS requires that applicants complete the EICS Affidavit and Release and the EICS Authorization for Release of Information, Documents, and Records forms that are attached below.

AFFIDAVIT AND RELEASE (FOR PHYSICIANS)

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 “Instructions for Completing the EICS Application” and have answered all questions contained in the application truthfully and completely.

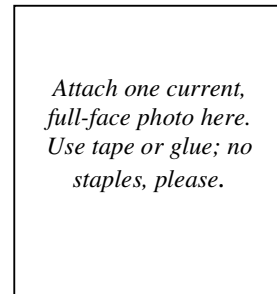
I authorize every person, medical school, university, hospital, clinic, government agency, or institution having custody or control of any documents, records, and other information pertaining to me to furnish to the Educational Commission for Foreign Medical Graduates (ECFMG®) International Credentials Services (EICS) any such information, or true and correct copies of documents or records.

I hereby release, discharge, and hold harmless ECFMG, the ECFMG International Credentials services, its employees, agents, or representatives, and any person furnishing information, records, or documents of any and all liability. I authorize the ECFMG International Credentials Services to release information, material, documents, orders, or the like relating to me or this application to Harvard Medical International (HMI) at my request.

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)



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 (FOR PHYSICIANS)

I, the undersigned, hereby authorize the Educational Commission for Foreign Medical Graduates (ECFMG®) International Credentials Services (EICS) to collect, verify, and maintain information and copies of documents and records in support of my Application for Professional License for Practice in Dubai Healthcare City.

I request and authorize every person, medical school, university, institution, professional licensing board, hospital, clinic, 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, and other information pertaining to me to the Educational Commission for Foreign Medical Graduates (ECFMG) International Credentials Services (EICS). I further request and authorize that the requested information, records, diplomas, transcripts, and other documents be sent directly to ECFMG International Credentials Services (EICS).

Immunity and Release

I hereby extend absolute immunity to, and release, discharge, and hold harmless from any and all liability: (1) the Educational Commission for Foreign Medical Graduates (ECFMG), (2) the ECFMG International Credentials Services (EICS), its employees, agents, representatives, directors, and officers; (3) other agencies, medical schools, universities, institutions, hospitals, and clinics providing information, their employees, representatives, directors, and officers; and (4) 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 Educational Commission for Foreign Medical Graduates (ECFMG) International Credentials Services. I understand that EICS 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.*

AFFIDAVIT ATTESTING TO PHYSICIAN PRACTICE

I, _____ THE UNDERSIGNED, DO HEREBY CERTIFY
Affiant Name

THAT I AM A LICENSED PHYSICIAN IN _____
Petitioner/Applicant's Jurisdiction

AND THAT I HAVE BEEN LICENSED IN THAT JURISDICTION FOR _____ YEARS, PRACTICING AS A _____
Affiant's specialty

I FURTHER CERTIFY THAT THE MAJORITY OF MY PRACTICE IN:
_____ IS IN THE AREA OF _____
Petitioner/Applicant's Jurisdiction Specialty

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS (DD/MM/YYYY): _____

Witness (Other than Petitioner/Applicant)

Affiant's signature

Please supply names, addresses and titles of two Professionals who can support this affidavit:

These should be from licensed practitioners who are familiar with your work in the jurisdiction from which you are applying:

NAME: _____ POSITION: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ EMAIL ADDRESS: _____

NAME: _____ POSITION: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ EMAIL ADDRESS: _____

10. 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