PEKELILING KETUA PENGARAH KESIHATAN – 16/2008

LAMPIRAN B

APPLICATION FORM FOR ELECTIVE POSTING
IN THE MINISTRY OF HEALTH MALAYSIAN FACILITIES

NOTE:
a. Please fill ALL compulsory fields marked* ; and
b. Please submit in TWO copies.

1. My Particulars:

1.1 Name in full (as in NRIC or passport) * : _____

1.2 a. NRIC Number (for Malaysian) : Old*: _____ New*: _____

b. Passport No.* (for Non-Malaysians): _____

1.3 Contact Number*: _____ 1.4 Email Address: _____

1.5 Home Address*: _____

_____ Postal Code: _____

1.6 Postal Address*: _____

_____ Postal Code: _____

1.7 Next of Kin*: _____

Address of Next of Kin*: _____

_____ Postal Code: _____

2. My Academic Background:

2.1 Name and address of parent medical school*: _____

_____ Postal Code : _____

2.2 Year of study*: _____

2.3 Expected year of graduation* : _____

2.4 Indicate briefly your clinical experience to date, if any:

Date	Disciplines	Duration

PEKELILING KETUA PENGARAH KESIHATAN – 16/2008

3. <u>The Particulars of Elective Posting Requested:</u>

3.1 Period of Elective Posting*:

From*: …… To: …… (Total = _____ weeks)

(The total length of the posting **should not exceed six weeks.** The minimum time spend in any particular discipline **should not be less than three weeks)**

3.2 My preferred Postings*:

Please indicate not more than three disciplines in terms of preference:

a. _____

b. _____

c. _____

Note: The authority has the right to determine any postings without reference to your application.

4. Herewith I enclose:

a. Certified photocopy of my identity card (for Malaysian) or passport (for foreigners) ; and

b. Supporting document/s from the Dean/University

5.Declaration:

I do hereby solemnly declare that:

a. All the particulars stated above are correct;

b. I have read and understand the provisions regarding the elective posting and agree to abide by and be governed by all the rules now in effect or as announced hereafter from time to time; and

c. I hereby agree to give an undertaking not to hold the hospital, clinic or the Ministry of Health responsible for any injury or mishaps sustained during the tenure of my posting.

Thank you.

Signature of Applicant*: …… Date*: …….

Please complete this form and return to the respective State Health Department or Institution and attach a letter from your institution requesting for the elective posting.