



APPLICATION FORM FOR VISITING CONSULTANTS (temporary registration)

Part I - To be completed by applicant

Note to the applicant: Please complete part I of this form, then send it to your sponsor. Please note that this form should be received by the Office of Licensure & Registration at least 4 weeks before your scheduled visit.

Contact information

Full name (as it appears in passport) _____

Address _____

Tel no. (residence) _____ Mobile no. _____

Tel no. (business) _____ Fax no. _____

E-mail _____

Personal details

Nationality _____

Passport number _____

Date of birth (day/month/year) _____

Gender _____

Medical qualifications

Highest degree _____ Date obtained _____

School/college _____ Country _____

Medical license

Licensing authority _____ Country _____

Current license number _____ Expiration date _____

Details of visit

Purpose _____

Sponsor _____

Duration of visit From: _____ To: _____

Attached documents

Copies of the following documents are attached:

☐ CV ☐ Medical license ☐ Professional/Educational certificate

Declaration

I hereby certify that the information provided herein is correct and truthful to the best of my knowledge.

Signature

Date

Part II - To be completed by the sponsor

Note to the sponsor: Please complete part II of this form, then submit it to: Office of Licensure & Registration, Ruffaedah, Ministry of Health, P.O. Box 12, Manama, Kingdom of Bahrain. Please note that this form should be received by the Office of Licensure & Registration at least 4 weeks before the scheduled visit.

Sponsor _____

Address _____

Contact person _____

Position title _____

Address _____

Tel no. _____ Fax no. _____ E-mail _____

Signature

Date

Responsible doctor at the institute who will work with the visiting doctor and follow-up on patients after the visiting doctor has left

Position title _____

Signature

Date

For official use