UNDERTAKING FOR ATTACHMENT/CLINICAL TRAINING PROGRAMME

**Confirmation and pledge**

**I applied for training at Sultan Qaboos**

**University Hospital (SQUH), and I pledge that I will:**

**إقرار وتعهد**

**أتعهد أنا الموقع أدناه بأنني تقدمت بطلب للتدريب بمستشفى جامعة السلطان قابوس على أن أراعي مايلي:**

 Adhere to the regulations and procedures applicable in SQUH.

 Adhere to the schedule for training and specific hours of attendance.

 Be responsible for all my behavior during the training period in SQUH.

 Adhere to the Dress Code for Medical Students and Doctors in Training (Document No: HWP-HDO-IPP-012), if I will join medical team.

 The SQUH will not assume any responsibility in case of any harm or accident which may happen during my training period.

 In the case of commission for any violation of the applicable regulations and laws by me, the training will be discontinued, and such case will be forwarded to the requesting institute.

 I must return the training identity card on the last day of my training period. In case of delay of more than 5 days from the last date of the training period, I lose my right to receive the refundable deposit.

 The training identity card is SQUH belonging and losing or not returning card could put me in legal issue.

**Trainee Name:**

**Card No:**

**Institute:**

**Signature:**

 الإلتزام بالأنظمة والإجراءات المعمول بها في مستشفى جامعة السلطان قابوس.

 التقيد بالبرنامج الزمني للتدريب والساعات المحـددة للحضور والانـصـراف.

 أن أكون مسئولا عن تصرفاتي خلال فترة التدريب بالمستشفى الجامعي .

 المستشفى الجامعي لن يتحمل أية مسؤلية في حالة حصول أي مكروه أو حادث أثناء فترة التدريب ، لا قدر الله.

 اذا كان المتدريب من الطاقم الطبي علية الالتيزام بـالانظمة المتبعة من خلال هذه الاستمارة

  (Dress Code for Medical Students and Doctors in Training (Document No:HWP-HDO-IPP-012)

 في حالة ارتكابي لأي إنتهاك للنظم والقوانين المعمول بها فإن للمستشفى الجامعي الحق لأنهاء التدريب دون سابق إنذار وسوف تحال هذه القضية للجهة المقدمه لطلب التدريب.

 يتعين عليّ إرجاع بطاقة التدريب في آخر يوم لفترة التدريب وفي حالة التأخير خلال مدة أقصاها 5 أيام من تاريخ نهاية فترة التدريب , افقد حقي في استرداد مبلغ الضمان .

 التعرض للمسألة القانونية في حالة فقدان أو أستخدام بطاقة التدريب بشكل غير قانوني لأنها ملك لمستشفى جامعة السلطان قابوس.

**الاسم:**

**رقم البطاقة:**

**الجهة الطالبة للتدريب:**

**الـتـوقـيــــع:**

**Note to the Applicants**:

(1) Card deposit charges:

(a) **Clinical Attachment Access or Observer ship -** OR.23 (refundable deposit OR.20; cost of the card is OR.3)

(b) **Non-Clinical Attachment** - OR.13 (refundable deposit is OR.10/-; cost of the card is OR.3/-) (2) There is no facility/provision for Transport, Food and Accommodation; these are to be arranged by the applicants themselves.

APPLICATION FOR ATTACHMENT/CLINICAL TRAINING PROGRAMME

***Please complete this form in English***

|  |
| --- |
| **Section 1: To be filled by the applicant** |

**Personal details of applicant:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

**Telephone/GSM:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program Requirement: CLINICAL ATTACHMENT NON-CLINICAL ATTACHMENT** *(please tick)*

**Specialty / Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DURATION: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPECIFIC OBJECTIVES FOR THE TRAINING:**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guidelines for applicant:**

(1) The completed application form should be submitted at least 4 weeks before the proposed date of attachment.

(2) The applicant should submit:

(i) Curriculum Vitae duly signed by the applicant.

(ii) Attested copies of the original certificate.

(iii) Evidence of passing the MoH clearance examination (Prometric for non-governmental employee)

(ii) Malpractice insurance (if applicable)

(iv) Non-governmental employee are also required to have a medical Insurance coverage and an appropriate type of visa (a No Objection letter will be provided as a supporting document for applying to this type of visa)

(3) Doctors who are not employed by governmental institutions and applying for a clinical attachment (clinical access or observer ship) are required to pay OR.250 (Rial Omani) per month.

(4) Nurses and allied health care professionals who are not employed by governmental institutions and applying for a clinical attachment (clinical Access or Observer ship) are required to pay OR.150 (Rial Omani) per month.

**Declaration: I will return the ID card issued to me on the last day of attachment and in case of losing it, I will be liable to pay the fees for the card.**

|  |
| --- |
| **Received by the Directorate of Training & Continuing Professional Development, SQUH**  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Section 2: To be filled by the concerned department Director/HOD** |

APPLICATION FOR ATTACHMENT/CLINICAL TRAINING PROGRAMME

**Name of the Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The above application for Clinical Attachment has been\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approved Not approved**

**For Clinical Access Observer ship**

**Note: For “Clinical Access” it is mandatory to produce malpractice insurance policy document to DTD. Please mention in writing that the candidate is approved for Clinical Access or Observer ship.**

If approved, confirm the period of training: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please state the reason/s (if not approved)**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Director/Head of Department)**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **PLEASE RETURN THE COMPLETED FORM TO DTD FOR FURTHER PROCESSING – THANK YOU** |