**APPLICATION FORM TO REQUEST FOR REISSUING OF INTERNSHIP CERTIFICATE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intern ID No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact No.: Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Internship Period**

Date Started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reasons:

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I pledge that the above written data is correct and I take all the responsibilities for any incorrect information.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note that all doctors who request for a duplicate copy of their Internship Certificate will pay an amount of **RO 20** as a charge fee and payment will be deposited to the College of Medicine Bank Account No: **0304008072340016 - Bank Muscat**

**Requirements:**

***To provide a copy of the following:***

- MD Certificate

- Internship Certificate

- Passport

- Copy of the deposit form for the certificate fee