**Sultan Qaboos University  جامعة السلطان قابوس**

**College of Medicine & Health Sciences**

**Internship Training Program**

**REGISTRATION FORM**

Date of Application:

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| **SECTION 1: PERSONAL DETAILS** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intern ID No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ National ID No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ College ID No.: \_\_\_\_\_\_\_\_\_\_\_\_\_  Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Region of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mobile No.: \_\_\_\_\_\_\_\_\_\_\_\_\_ Home Tel./Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PROGRAM REQUIREMENT:** MD Certificate or Letter of Graduation (*please tick*) |
| **SECTION 2: CONTACT PERSON IN CASE OF EMERGENCY** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mobile No.: \_\_\_\_\_\_\_\_\_\_\_\_\_ Home Tel./Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SECTION 3: START OF ROTATION** |
| 1st August 20\_\_\_\_ 1st December 20\_\_\_\_ 1st April 20 \_\_\_\_ Other 20\_\_\_\_  (***please tick and attach copy***) |
| **DECLARATION:**  I the Intern doctor who’s information is mentioned above pledge and acknowledge the following:  1. All of the above information has been filled out by me and is true.  2. I know and acknowledge that the rotations cannot be modified after they have been assigned by the internship office.  3. I understand that I am entitled to take leave only after filling the necessary forms for this and taking approval from the department and internship office.  4. I have learned that I am not entitled to interrupt or postpone any rotation until I have informed and taken approval from the internship office.  5. I understand that I must apply for the elective period at least 2 weeks before the start of the elective and that the chairman of the internship committee has the right to approve or reject the application.  6. I understand that only one of my rotation requests may be granted.  7. I understand that I need to inform my internship coordinator about my health issues.  8. I have read and I understand the general rules and regulations of the internship program whereas the intern will be responsible for his/her own acts and omission during internship and the College of Medicine will not indemnify to any intern for his/her act and omission during internship period.  9. I fully agree to abide with the rules and regulations of the internship program.  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ |

**TO BE FILLED BY THE INTERNSHIP OFFICE:**

Received by: Signature: Date:

**KINDLY RETURN THE COMPLETED FORM TO THE INTERNSHIP OFFICE**

**OR YOU CAN SEND IT TO:** [**interns.medtcs@gmail.com**](mailto:interns.medtcs@gmail.com) **– THANK YOU**