SULTAN AHMAD SHAH MEDICAL CENTRE @IIUM
FORM APPLICATION FOR SUBSPECIALTY TRAINING
AT SULTAN AHMAD SHAH MEDICAL CENTRE @IIUM

SESSION: | | | | |

*subject to change

All information must be filled in completely. Incomplete/inaccurate documents will not be processed.

A	**PERSONAL DETAILS**	
1	NAME (FOLLOW IC)	
2	IDENTIFICATION NO: *Please include a copy of your IC that has been verified*	
3	GENDER	
4	AGE	
5	HOME ADDRESS	
6	WORK ADDRESS	
7	CONTACT NUMBER	
8	EMAIL ADDRESS	
9	MARITAL STATUS	☐ SINGLE ☐ MARRIED ☐ DIVORCED
10	NAME OF SPOUSE (IF APPLICABLE)	
11	SPOUSE'S OCCUPATION	
12	SPOUSE'S WORK ADDRESS (*in full, if applicable)*	
13	CONTACT NUMBER OF NEXT-OF-KIN	
14	NAME & AGE OF CHILDREN (IF ANY)	

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B	ACADEMIC INFORMATION	
1	BASIC DEGREE UNIVERSITY: YEAR: SCHOLARSHIP (IF ANY):	
2	POSTGRADUATE QUALIFICATION / EQUIVALENT UNIVERSITY: YEAR: SCHOLARSHIP (IF ANY):	

C	DETAILS OF SERVICE	
1	CURRENT GRADE	UD
2	DEPARTMENT	
3	EMPLOYMENT STATUS	☐ PERMANENT ☐ CONTRACT
4	DATE OF APPOINTMENT	
5	DATE OF CONFIRMATION IN SERVICE	
6	MMC NUMBER	
7	DATE OF FULL MMC REGISTRATION	
8	DATE OF SPECIALIST GAZETTEMENT	
9	DURATION OF EXPERIENCE AS A SPECIALIST	
10	NSR NUMBER	
11	DATE OF NSR REGISTRATION	

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D	**WORK EXPERIENCE**			
1	HOUSEMANSHIP	HOSPITAL		
		DEPARTMENT		DATE
		1. 2. 3. 4. 5. 6.		
2	PRIOR TO POSTGRADUATE QUALIFICATION / EQUIVALENT	DATE / DURATION	HOSPITAL / DEPARTMENT	CONSULTANT
3	AFTER POSTGRADUATE QUALIFICATION / EQUIVALENT	DATE / DURATION	HOSPITAL / DEPARTMENT	CONSULTANT

E	**CHOICE OF SUBSPECIALTY TRAINING**

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F	**PROPOSED TRAINING PLAN**		
	YEAR OF TRAINING	CENTRE	SUPERVISOR
	YEAR 1 YEAR 2 YEAR 3		

G	**REFEREE**
	Please name two (2) referees that are well-informed with your clinical skills and are your immediate supervisor(s). Both referees must complete form IIUM-IIUMMC-CMU-F019 and seal the document upon completion. The documents must be submitted along with the application form. ***Referee 1*** NAME: POSITION: PLACE OF PRACTICE: ***Referee 2*** NAME: POSITION: PLACE OF PRACTICE:

H	**PUBLICATIONS / RESEARCH / ORAL PRESENTATION** *Please list chronologically, from the most recent*
	Attach separate sheet if space insufficient

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I	**INVOLVEMENT IN PROFESSIONAL ORGANIZATIONS** *Please list chronologically, from the most recent*
	Attach separate sheet if space insufficient

J	**DECLARATION**
	1. I hereby declare that I am free of any disease resulting in me being unfit to practice both physically and mentally as listed in the Appendix A (as per Act 1971), including infectious diseases, blood-borne diseases (such as HIV, AIDS etc.). If I am found to have any of these diseases, I agree that SASMEC @IIUM can revoke my application immediately without prior notification. 2. I hereby declare that I have read and understood the contract with the University in the event that I fail to complete subspecialty training. 3. I agree with the terms and conditions set out by the University upon completing subspecialty training. 4. I declare that all the information given above is accurate and that the application is complete. Should there be any inaccuracies in the information provided or the application is incomplete, I agree that SASMEC @IIUM can reject this application.

DATE: **SIGNATURE & OFFICIAL STAMP:**

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LIST OF CHRONIC DISEASES **Appendix A**

A. Malignancy

B. Cardiovascular disease

C. Pulmonary hypertension

D. Chronic Kidney Disease

E. Chronic Liver Disease

F. Hepatitis

G. Traumatic Brain Injury

H. Tumor and abnormality of vessels in brain

I. Blistering and burns due to fire

J. Main organ transplant

K. Parkinson's Disease

L. HIV and/or AIDS

M. Hand or foot transplant

N. Schizophrenia

O. Any injuries or disabilities acquired during the training or the course which are validated by the Medical Officer verified by the Hospital Management as unfit to continue the studies; and

P. Other diseases which are declared as chronic diseases and unfit to continue the studies by the Medical Officer verified by the Hospital Management