GOVERNMENT OF DUBAI

DUBAI HEALTHCARE CITY AUTHORITY

Application for Medical/Dental License

Exclusive licensure for practicing in Dubai Healthcare City

☐ **Operator sponsoring application (indicate name of clinical facility):** _____
If you tick the above box please attach Letter of Intent/Offer Letter from the clinical facility

☐ **No operator (Please notify Licensing Department when you start work at DHCC)**
Please seek information on Letter of Acceptance (LOA)

Please check box that applies:

☐ **General Medical License** ☐ **Medical Specialty License** **Specialty applied for:** _____

☐ **Dental License** ☐ **Dental Specialty License** **Specialty applied for:** _____

ALL FIELDS ARE MANDATORY

Please type or print clearly in ENGLISH LANGUAGE

1. Name: Please enter your complete name and any maiden/previous name as per passport.

LAST NAME: _____

FIRST AND MIDDLE NAME(S): _____

MAIDEN NAME(S): _____

PREVIOUS NAME(S): _____

2. Contact Information: Please provide ONE mailing address only.

STREET ADDRESS/POST OFFICE BOX: _____

_____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ MOBILE NUMBER: _____

FACSIMILE NUMBER: _____ E-MAIL ADDRESS 1: _____

E-MAIL ADDRESS 2: _____

3. Date and Place of Birth: Please enter your date and place of birth as per passport.

DAY: _____ MONTH: _____ YEAR: _____

COUNTRY OF BIRTH: _____ CURRENT NATIONALITY/ CITIZENSHIP: _____

4. Gender: Please check one.

☐ MALE ☐ FEMALE

5. Identification Details: *Please fill in the details and attach copies.*

PASSPORT NUMBER: _____ COUNTRY OF ISSUE: _____EXPIRY DATE: _____

UAE ID CARD NO. : _____ EXPIRY DATE: _____

6. Have you ever applied for a Physician/Dentist License to Practice in DHCC? ☐ ***YES*** ☐ ***NO***

IF YES, PLEASE LIST DHCC LICENSE NUMBER/LOA OR ATTACH COPY: _____

7. Languages Spoken: *Please fill in the details.*

☐ ARABIC ☐ ENGLISH OTHERS: _____ _____

8. Language Proficiency.

WAS ENGLISH THE LANGUAGE OF INSTRUCTION FOR YOUR MEDICAL/DENTAL DEGREE? ☐ YES ☐ NO

IF NO, WHAT WAS THE LANGUAGE OF INSTRUCTION? _____

IF ENGLISH WAS NOT THE LANGUAGE OF INSTRUCTION OF YOUR MEDICAL/DENTAL DEGREE, HAVE YOU EVER TAKEN THE ENGLISH PROFICIENCY TEST?

☐ YES ☐ NO

IF YOU HAVE TAKEN THE ENGLISH PROFICIENCY TEST,

SCORE: _____. PLEASE ATTACH COPY OF ENGLISH PROFICIENCY TEST RESULT
Please refer to the Healthcare Professionals Regulation under Schedule Two for details on English proficiency requirements.

9. Medical/Dental License/Registration: *Please list all jurisdictions in which a license/registration to practice has been obtained. Include permanent, limited, and other special purpose licenses/registrations.*

FULL NAME OF LICENSING/REGISTRATION JURISDICTION: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

LICENSE/ REGISTRATION CATEGORY: _____ LICENSE/REGISTRATION NUMBER: _____

LICENSE ISSUE DATE (DD/MM/YYYY): _____ LICENSE EXPIRATION DATE (DD/MM/YYYY): _____

LICENSE REGISTRATION STATUS (CHECK ONE):

☐ ACTIVE ☐ INACTIVE ☐ SUSPENDED ☐ REVOKED

If the license/registration is suspended or revoked, please provide information.

Other Jurisdiction(s) Where A License/Registration Was Obtained (if applicable)

FULL NAME OF LICENSING/REGISTRATION JURISDICTION: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

LICENSE/ REGISTRATION CATEGORY: _____ LICENSE/REGISTRATION NUMBER: _____

LICENSE ISSUE DATE (DD/MM/YYYY): _____ LICENSE EXPIRATION DATE (DD/MM/YYYY): _____

LICENSE REGISTRATION STATUS (CHECK ONE):

☐ ACTIVE ☐ INACTIVE ☐ SUSPENDED ☐ REVOKED

If the license/registration is suspended or revoked, please provide information.

If additional sheet(s) are required for listing other license/registration, please attach

10. Medical/Dental College/University: *Please list all Medical/Dental College/University attended after obtaining high school/secondary education diploma/certificate; not just the one from which you graduated.*

FULL NAME OF COLLEGE/UNIVERSITY: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

ATTENDED FROM (DD/MM/YYYY): _____ TO (DD/MM/YYYY): _____

GRADUATION DATE (DD/MM/YYYY): _____

DEGREE/QUALIFICATION OBTAINED (e.g. Pre Med/MD/MBBS/MBChB/DDS/BDS/DDM): _____

Other College(s)/University(s) Attended

FULL NAME OF COLLEGE/UNIVERSITY: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

ATTENDED FROM (DD/MM/YYYY): _____ TO (DD/MM/YYYY): _____

GRADUATION DATE (DD/MM/YYYY): _____

DEGREE/QUALIFICATION OBTAINED (e.g. Pre Med/MD/MBBS/MBChB/DDS/BDS/DDM): _____

If additional sheet(s) are required for listing other Medical/Dental College/University, please attach

11. Postgraduate Education: *Please list all Postgraduate Medical/Dental Education obtained after graduation from College/University. This shall include Internship, Supervised Clinical Training/Residency, Masters, etc.*
Note: *Please ensure no gaps in training unless justified with evidence.*

PLEASE DESCRIBE YOUR SPECIALTY TRAINING PROGRAM: _____

_____

FULL NAME OF INSTITUE/HOSPITAL: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

ATTENDED FROM (DD/MM/YYYY): _____ TO (DD/MM/YYYY): _____

WAS THE POSTGRADUATE MEDICAL/DENTAL EDUCATION COMPLETED: ☐ ***YES*** ☐***NO***

IF YES,

WHAT QUALIFICATION/RESIDENCY WAS OBTAINED: _____

COMPLETION DATE (DD/MM/YY): _____

Other Postgraduate Medical/ Dental Education

PLEASE DESCRIBE YOUR SPECIALTY TRAINING PROGRAM: _____

_____

FULL NAME OF INSTITUE/HOSPITAL: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

ATTENDED FROM (DD/MM/YY): _____ TO (DD/MM/YY): _____

WAS THE POSTGRADUATE MEDICAL/DENTAL EDUCATION COMPLETED: ☐ ***YES*** ☐***NO***

IF YES,

WHAT QUALIFICATION/RESIDENCY WAS OBTAINED: _____

COMPLETION DATE (DD/MM/YYYY): _____

If additional sheet(s) are required for listing other Postgraduate Medical/Dental Education, please attach

12. Specialty Board or Equivalent: *Please list Specialty Board certification obtained after completing the Post Graduate Medical/Dental Education*

ARE YOU BOARD CERTIFIED IN YOUR SPECIALTY?

☐ YES ☐ NO

NAME OF SPECIALITY BOARD: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

DATE CERTIFICATION OBTAINED (DD/MM/YYYY): _____

BOARD IDENTIFICATION NUMBER (If applicable): _____

Other Specialty Board or Equivalent:

NAME OF SPECIALITY BOARD: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

DATE CERTIFICATION OBTAINED (DD/MM/YYYY): _____

BOARD IDENTIFICATION NUMBER (If applicable): _____

If additional sheet(s) are required for listing other specialty board, please attach

13. Professional Membership/Affiliations: *Please provide a summary of your professional Membership/Affiliation activities since completion of your Postgraduate Medical/Dental Education (Please list the active ones)*

FULL NAME OF INSTITUTION/ASSOCIATION: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

MEMBERSHIP/AFFILIATION FROM (DD/MM/YY):_____ TO DD/(MM/YY): _____

Other Institution(s)

FULL NAME OF INSTITUTION/ASSOCIATION: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

STATE/PROVINCE: _____COUNTRY:_____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____
Please provide official email address; personal email address will not be accepted.

MEMBERSHIP/AFFILIATION FROM (DD/MM/YYYY):_____ TO DD/(MM/YYYY): _____

If additional sheet(s) are required for listing other Professional Membership/Affiliation, please attach

14. Work Experience: *Please provide a summary of your professional practice for at least the last fifteen (15) years (if applicable).*
Note: *Please ensure no gaps in practice unless justified with evidence.*

APPOINTMENT/POSITION TITLE	NAME AND ADDRESS OF INSTITUTE OF PRACTICE	CLINICAL DEPARTMENT/AREA OF PRACTICE	FROM (DD/MM/YYYY)	TO (DD/MM/YYYY)

If additional sheet(s) are required for listing other work experiences, please attach.

15. Outpatient Clinical Privileges

PHYSICIANS:
Please complete a physician privileging form (available in CPQ website: http://www.cpq.dhcc.ae/cpq/licensing-prospective-clients/).
This does not substitute for hospital privileging.

DENTISTS:
Please complete a dental privileging form (available in CPQ website: http://www.cpq.dhcc.ae/cpq/licensing-prospective-clients/).
This does not substitute for hospital privileging.

16. Additional Questions: Please answer the following questions.

1. SINCE YOUR ENROLLMENT IN MEDICAL/DENTAL SCHOOL, HAVE YOU BEEN SUBJECT TO ANY DISCIPLINARY ACTION AT AN ACADEMIC INSTITUTION?

☐ YES ☐ NO

2. SINCE YOUR ENROLLMENT IN MEDICAL/DENTAL SCHOOL, HAVE YOU BEEN DENIED THE PRIVILEGE OF TAKING OR FINISHING AN EXAMINATION OR BEEN ACCUSED OF CHEATING AND/OR IMPROPER CONDUCT DURING AN EXAMINATION?

☐ YES ☐ NO

3. HAVE YOU BEEN TERMINATED OR GRANTED A LEAVE OF ABSENCE BY A MEDICAL/DENTAL SCHOOL OR MEDICAL/DENTAL POST-GRADUATE TRAINING PROGRAM OR HAVE YOU EVER WITHDRAWN FROM A MEDICAL/DENTAL SCHOOL OR MEDICAL/DENTAL POSTGRADUATE TRAINING PROGRAM OR HAD TO REPEAT A YEAR OF POSTGRADUATE TRAINING?

☐ YES ☐ NO

4. HAVE YOU EVER APPLIED FOR LICENSURE OR TO SIT FOR AN EXAMINATION OR TAKEN AN EXAMINATION UNDER A DIFFERENT NAME? *IF YES, THEN LIST ALL PREVIOUS NAMES AND OCCASION ON WHICH THEY WERE USED.*

☐ YES ☐ NO

5. DO YOU CARRY MEDICAL MALPRACTICE INSURANCE?
IF YES, PLEASE INCLUDE A COPY OF YOUR MEDICAL MALPRACTICE INSURANCE POLICY.

☐ YES ☐ NO

6. DO YOU POSSESS A SPECIFIC LICENSE TO PRESCRIBE NARCOTIC MEDICATION, E.G. A UNITED STATES DEA LICENSE?

☐ YES ☐ NO

7. HAVE YOU EVER, FOR ANY REASON, BEEN DENIED A MEDICAL LICENSE, WHETHER FULL, LIMITED, TEMPORARY, OR HAVE YOU WITHDRAWN AN APPLICATION FOR MEDICAL LICENSURE?

☐ YES ☐ NO

8. HAVE YOU EVER VOLUNTARILY SURRENDERED A LICENSE TO PRACTICE MEDICINE?

☐ YES ☐ NO

9. HAVE YOU EVER, FOR ANY REASON, LOST OR BEEN DENIED REQUIRED RE-CERTIFICATION BY ANY SPECIALTY BOARDS IN ANY JURISDICTION?

☐ YES ☐ NO

10. ARE ANY FORMAL DISCIPLINARY CHARGES PENDING AGAINST YOU, OR DO YOU HAVE KNOWLEDGE OF ANY PENDING INVESTIGATION INTO YOUR PROFESSIONAL COMPETENCE OR CONDUCT BY ANY GOVERNMENTAL AUTHORITY, HEALTH CARE FACILITY, GROUP PRACTICE OR PROFESSIONAL MEDICAL SOCIETY OR ASSOCIATION IN ANY JURISDICTION? ?

☐ YES ☐ NO

11. HAS ANY DISCIPLINARY ACTION EVER BEEN TAKEN AGAINST YOU FOR VIOLATION OF LAWS, RULES, BY-LAWS, OR STANDARDS OF PRACTICE BY ANY GOVERNMENT AUTHORITY, HEALTHCARE FACILITY, GROUP OR PROFESSIONAL MEDICAL SOCIETY OR ASSOCIATION IN ANY JURISDICTION?

☐ YES ☐ NO

12. HAS YOUR MEDICAL/DENTAL STAFF MEMBERSHIP, MEDICAL/DENTAL PRIVILEGES OR MEDICAL STAFF STATUS IN ANY HOSPITAL, CLINIC, OR OTHER SUCH FACILITY IN ANY JURISDICTION BEEN LIMITED, SUSPENDED, REVOKED, NOT RENEWED OR SUBJECT TO PROBATIONARY CONDITIONS OR IS PROCESSING TOWARDS ANY OF THOSE ENDS BEEN INSTITUTED OR RECOMMENDED BY A MEDICAL/DENTAL STAFF COMMITTEE OR GOVERNING BOARD?

☐ YES ☐ NO

13. HAVE YOU EVER BEEN CHARGED WITH ANY CRIMINAL OFFENSE, OTHER THAN A MINOR TRAFFIC OFFENSE, IN ANY JURISDICTION?

☐ YES ☐ NO

14. IN THE PAST (10) YEARS, HAS ANY MEDICAL MALPRACTICE CLAIM BEEN MADE AGAINST YOU IN ANY JURISDICTION, WHETHER OR NOT A LAWSUIT WAS FILED IN RELATION TO THE CLAIM?

☐ YES ☐ NO

15. IN THE LAST (10) YEARS, HAS ANY LAWSUIT, OTHER THAN A MEDICAL MALPRACTICE SUIT, WHICH IS RELATED TO YOUR COMPETENCY TO PRACTICE MEDICINE, OR YOUR PROFESSIONAL CONDUCT IN THE PRACTICE OF MEDICINE, BEEN FILED AGAINST YOU OR HAS SUCH A SUIT BEEN SETTLED, ADJUDICATED OR OTHERWISE RESOLVED?

☐ YES ☐ NO

16. HAVE YOU BEEN DIAGNOSED WITH OR TREATED FOR A MEDICAL CONDITION THAT IN ANY WAY CURRENTLY LIMITS OR IMPAIRS YOUR ABILITY TO PRACTICE MEDICINE OR TO FUNCTION AS A PHYSICIAN?

☐ YES ☐ NO

17. DO YOU CURRENTLY HAVE A MEDICAL CONDITION THAT IN ANY WAY LIMITS OR IMPAIRS YOUR ABILITY TO PRACTICE MEDICINE OR TO FUNCTION AS A PHYSICIAN?

☐YES ☐ NO

18. WITHIN THE PAST TWO YEARS, HAVE YOU ENGAGED IN THE USE OF CHEMICAL SUBSTANCES WITH THE RESULT THAT YOUR ABILITY TO PRACTICE MEDICINE IS CURRENTLY IMPAIRED OR LIMITED?

☐ YES ☐ NO

19. HAVE YOU EVER REFUSED TO SUBMIT TO A TEST TO DETERMINE WHETHER YOU HAD CONSUMED AND/OR WERE UNDER THE INFLUENCE OF CHEMICAL SUBSTANCES?

☐ YES ☐ NO

20. ARE YOU CURRENTLY ENGAGED IN THE ILLEGAL USE OF DRUGS OR MISUSE OF PRESCRIPTION DRUGS?

☐ YES ☐ NO

21. HAVE YOU EVER BEEN ACCUSED OF FRAUDULENT MEDICAL/DENTAL PRACTICE OR FRAUDULENT MEDICAL BILLING PRACTICES?

☐ YES ☐ NO

22. HAVE YOUR PRIVILEGES TO PRESCRIBE NARCOTICS EVER BEEN REVOKED?

☐ YES ☐ NO

All information will be subject to DHCC Laws of Confidentiality.

Submission of Completed Application

Please request for an appointment with the Licensing Department to assess eligibility for licensure and completeness of your application by sending an email to info@cpq.dhcc.ae .

If you are not available to meet, please send via courier the completed application to the below address:

Licensing Department
Centre for Healthcare Planning and Quality (CPQ)
Ibn Sina Building, Block B, Ground Floor
Dubai Healthcare City
Oud Metha Road
Dubai, United Arab Emirates
Tel: +971-4-362-2790, Fax: +971-4-362-4770

The Licensing Department contact details are listed below:

Licensing Department
Centre for Healthcare Planning and Quality (CPQ)
Dubai Healthcare City
P.O. Box 505001
Dubai, United Arab Emirates
Tel: +971-4-362-2790, Fax: +971-4-362-4770

Documentation Checklist: *Please return the following.*

☐ COMPLETED APPLICATION (All applicable information's should be completed in ENGLISH)

☐ POLICE CLEARANCE CERTIFICATE FROM COUNTRY OF LAST CONTINUOUS PRACTICE (5YEARS)

☐ COMPLETED OUTPATIENT CLINICAL PHYSICIANS/DENTISTS PRIVILEGING FORM

☐ TWO (2) PASSPORT-SIZED PHOTOS

☐ COMPLETED AFFIDAVIT AND RELEASE (PHYSICIANS/DENTISTS) - Page 12

☐ COMPLETED AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS (PHYSICIANS/DENTISTS) - Page 13

☐ AFFIDAVIT ATTESTING LETTERS - Page 14

☐ TWO RECOMMENDATION FORMS, OF WHICH ONE IS FROM A CLINICAL SUPERVISOR. BOTH SHOULD PREFERABLY BE PROVIDED BY PROFESSIONALS (EXLCUDING RELATIVES) WHO HAVE WORKED WITH YOU IN THE PAST FIVE (5) YEARS.

☐ **TWO (2) COPIES EACH**, INCLUDING CERTIFIED ENGLISH TRANSLATIONS IF ORIGINAL DOCUMENTS ARE NOT IN ENGLISH, OF:

- MEDICAL/DENTAL DEGREE CERTIFICATE(s) (authenticated copy(s) is required)
- MEDICAL/DENTAL COLLEGE/UNIVERSITY TRANSCRIPTS
- SPECIALITY BOARD CERTIFICATE(s) (authenticated copy(s) is required)
- RESIDENCY/TRAINING LETTERS (PROOF OF POSTGRADUATE MEDICAL/ DENTAL EDUCATION) FROM INSTITUTE/HOSPITAL
- MEDICAL LICENSE(s)/REGISTRATION(s) (authenticated copy(s) is required) AND CERTIFICATE OF GOOD STANDING (CGS) FROM THE LICENSING AUTHORITY/(s)

☐ PASSPORT (INLCUDING IMAGE, SIGNATURE AND NUMBER) AND UAE ID CARD (IF APPLICABLE)

☐ MEDICAL MALPRACTICE INSURANCE (MMI) POLICY (issued by UAE based insurer covering DHCC, UAE)
Note: MMI shall be deemed required after approval and prior to commencing clinical practice

☐ CURRICULUM VITAE SIGNED BY THE APPLICANT- To include chronological account (DD/MM/YYYY) of your training and professional career.

☐ OFFICIAL EMPLOYMENT LETTER FOR THE LAST FIVE (5) YEARS. (THIS LETTER SHOULD BE SIGNED AND STAMPED BY AN AUTHORIZED SIGNATORY OF THE EMPLOYER)

☐ ENGLISH PROFICIENCY TEST RESULTS (if applicable)

☐ APPLICATION FEES (once submitted, fees will NOT be refundable for any reason).

☐ PROOF OF FIFTY (50) HOURS OF ACCREDITED CONTINUOUS MEDICAL EDUCATION (CME) OBTAINED WITHIN THE IMMEDIATE PAST TWO (2) YEARS

PLEASE PROVIDE ADDITIONAL DOCUMENTATION FOR APPLICANTS SEEKING LICENSURE VIA Option Three of "GUIDELINES FOR PHYSICIAN/DENTAL LICENSURE WITHIN DHCC": Please seek guidance from Licensing Department.

PRIMARY SOURCE VERIFICATION

As part of the Application for Professional License to Practice in Dubai Healthcare City (DHCC), certain credentials must be verified for authenticity. These credentials include, at the minimum, medical school degrees/diplomas, medical school transcripts, medical license/registration certificates in other jurisdictions, postgraduate training certificates and board certification. The Licensing department at the Center for Healthcare Planning and Quality (CPQ) will obtain primary source verification for the authenticity of these documents from the source/s that issued them.

The Licensing Department will submit copies of your documents to be verified to the respective authorities to secure primary source verification of submitted credentials. The Licensing Department will request that an authorized institution official complete the verification request form and return it directly to CPQ. If the Licensing Department does not receive verification of a document within the set target timeline then the application will become inactive.

In order to begin this process, the Licensing Department requires that applicants complete the Affidavit and Release (Page 12) and the Authorization for Release of Information, Documents, and Records (Page 13) forms that are attached.

The PSV performed by the Licensing Department is a verification intended for DHCA Licensure. This is a report of authenticity of the presented documents. Once verified, your credentials will be evaluated by the Licensing Department, Professional Council and the DHCA Licensing Board for review and decision.

NOTES TO CONSIDER:

- ***YOU ARE REQUIRED TO SUBMIT A COPY OF YOUR BASIC LIFE SUPPORT (BLS) AS A MINIMUM TO COMMEMCE PRACTICE AFTER APPROVAL. HEALTHCARE PROFESSIONALS SUCH AS ANESTHESIOLOGISTS, PARAMEDICS, ETC ARE REQUIRED TO HAVE CERTIFICATION IN ACLS AS A MINIMUM.***
- ***APPLICANTS WITH PENDING/SETTLED LEGAL ISSUES ARE REQUIRED TO PROVIDE A FINAL COURT STATEMENT, MEDICAL BOARD ACTION REPORT AND/OR MEDICAL MALPRACTICE CLAIMS STATUS REPORT.***
- ***APPLICANTS ARE REQUIRED TO IMMEDIATELY NOTIFY THE LICENSING DEPARTMENT, CENTER FOR HEALTHCARE PLANNING AND QUALITY (CPQ) OF ANY CHANGES OR NEW INFORMATION RELATED TO THE APPLICATION.***
- ***ALL MATERIALS SENT AS PART OF THIS APPLICATION PROCESS WILL BE RETAINED BY CPQ LICENSING DEPARTMENT AND WILL NOT BE RETURNED TO THE APPLICANT.***
- ***UPON REVIEW OF THIS APPLICATION, AN INTERVIEW MAY BE REQUESTED. IN ADDITION, CPQ LICENSING DEPARTMENT RESERVES THE RIGHT TO ACCEPT OR DENY ANY APPLICANT FOR DHCC LICENSURE AT ITS SOLE DISCRETION.***

ACKNOWLEDGEMENT:

- ***I HEREBY CONFIRM THAT THE INFORMATION AND DOCUEMNTATION I HAD PRESENTED IS TRUTHFUL AND I AUTHORIZE CPQ LICENSING DEPARTMENT TO CONTACT MY UNIVERSITY/(S), HOSPITAL/(S), TRAINING PROGRAM/(S), AND REFERENCES FOR PURPOSE OF PRIMARY SOURCE VERIFICATION (PSV).***
- ***PLEASE NOTE BY SIGNING THIS FORM "I ACKNOWLEDGE THAT INFORMATION ABOUT ME RELEVANT TO MY PRACTICE MAY BE MADE PUBLIC; I AM AWARE OF THE REQUIREMENT ON ME TO REPORT TO THE COMPLIANCE & ASSURANCE DEPARMENT IN CPQ ANY HEALTHCARE PROFESSIONAL WHO IS IMPAIRED OR DISABLED FOR WHATEVER REASON AND WHO'S IMPAIRMENT CONSTITUTES A PUBLIC RISK."***

_____ _____

SIGNATURE **DATE (DD/MM/YYYY)**

AFFIDAVIT AND RELEASE (PHYSICIANS/DENTISTS)

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make on or in connection with the application are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies I furnish with my application are true and correct.

I acknowledge that I have read and understood the application form and have answered all questions contained in it truthfully and completely.

I authorize every person, medical college, university, hospital, clinic, government agency, or institution having custody or control of any documents, records, and other information pertaining to me to furnish to the Licensing Department, CPQ any such information, or true and correct copies of documents or records.

I hereby release, discharge, and hold harmless Licensing Department, CPQ, its employees, agents, or representatives, and any person furnishing information, records, or documents of any and all liability. I authorize the Licensing Department, CPQ to release information, material, documents, orders, or the like relating to me or this application to other entities or third party at my request.
.

_____
Applicant's Signature (must be signed in the presence of a notary public, consular official, or first class magistrate)

_____
Applicant's printed last name, first name, middle initial, suffix (e.g., Jr.)

_____
Date of signature (DD/MM/YYYY)
Date must correspond to the date of notarization

Attach one current full-face photo here. Use tape or glue; no staples, please.

Sign across the bottom or top of the photo. Do not sign at the back.

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this individual by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the individual and with the photograph affixed hereto, and (b) comparing the individual's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn before me by the individual on this _____ day, in the month of _____, in the year _____

X

_____
Signature of Consular Official, First Class Magistrate, Notary Public (in Latin characters with English translations, where applicable.)

_____
Official Title

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS (PHYSICIANS/DENTISTS)

I, the undersigned, hereby authorize the Licensing Department, CPQ to collect, verify, and maintain information and copies of documents and records in support of my Application for Professional License for Practice in Dubai Healthcare City.

I request and authorize every person, medical college, university, institution, professional licensing board, hospital, clinic, government agency, or other third parties and organizations and their representatives to release information, records, diplomas, transcripts, and other documents concerning my professional education, qualifications, experience and competence, ethics, character, and other information pertaining to me to the Licensing Department, CPQ. I further request and authorize that the requested information, records, diplomas, transcripts, and other documents be sent directly to the Licensing Department, CPQ.

Immunity and Release

I hereby extend absolute immunity to, and release, discharge, and hold harmless from any and all liability: (1) Licensing Department, CPQ, its employees, agents, representatives, directors, and officers; (2) other agencies, medical schools, universities, institutions, hospitals, and clinics providing information, their employees, representatives, directors, and officers; and (3) any third parties and organizations for any acts, communications, reports, records, diplomas, transcripts, statements, documents, recommendations, or disclosures involving me, made in good faith and without malice, requested and received by the Licensing Department, CPQ. I understand that Licensing Department, CPQ will not accept such information, records, or documents forwarded by me.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid from the date signed.

_____
Signature

_____
Date of signature (DD/MM/YYYY)

_____
Printed last name, first name, middle initial, suffix (e.g., Jr.)

_____
Date of birth (DD/MM/YYYY)

Attach one current full-face photo here. Use tape or glue; no staples, please.

Sign across the bottom or top of the photo. Do not sign at the back.

AFFIDAVIT ATTESTING TO PHYSICIANS/DENTISTS PRACTICE

I, _____ THE UNDERSIGNED, DO HEREBY CERTIFY THAT I AM A LICENSED PHYSICIAN/DENTIST
Affiant Name

PRACTICING IN THE FOLLOWING JURISDICATION(s)_____ AND THAT I HAVE BEEN
Petitioner/Applicant's Jurisdiction (e.g DHA, GMC, Etc)

LICENSED IN THE ABOVE JURISDICTION/(s) FOR THE LAST _____ YEARS, PRACTICING AS A _____
Affiant's specialty

I FURTHER CERTIFY THAT THE MAJORITY OF MY PRACTICE HAS BEEN IN THE ABOVE MENTIONED JURISDICATION(s) AND SPECIALITY

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS (DD/MM/YYYY): _____

_____ _____
Witness (Other than Petitioner/Applicant) Affiant's signature

Please supply names, addresses and titles of two Professional who can support this affidavit:

These should be from licensed practitioners who are familiar with your work in the jurisdiction/(s) in which you held previous licensure:

1. NAME: _____ POSITION: _____

PLACE OF PRACTICE & ADDRESS:_____

_____

TELEPHONE/MOBILE NUMBER: _____ EMAIL ADDRESS: _____

2. NAME: _____ POSITION: _____

PLACE OF PRACTICE & ADDRESS:_____

_____

TELEPHONE/MOBILE NUMBER: _____ EMAIL ADDRESS: _____