**State of Qatar**
**Supreme Council of Health**

# Evaluation Application Form

## Medical Licensing

**Registration Section**

## Personal Details

Name ( as in passport )

First Name ..... Middle Name ..... Family .....

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Nationality ..... Gender Female ☐ Male ☐

Date of Birth ..... Mobile No .....

Phone No ..... P.O.Box ..... Fax No .....

E - mail .....

Private Sector ☐

Public Sector ☐

Qatari ☐

Non-Qatari ☐

Submitted by (Employer)

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Has any Displinary action ever been taken against you as a result of violations related to your profession ?

Yes ☐

No ☐

If yes, Explain

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## Profession

1-Physician ☐

2-Dentist ☐

3-Nurse ☐

4-Allied-Health Professional ☐

Specify .....

Requested Job Title (scope of practice)

.....

Name of applicant .....

Date .....

Signature .....