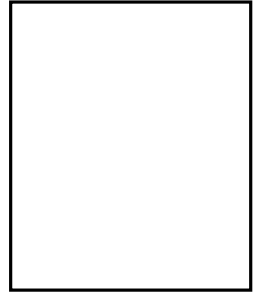




Ministry of Health
Kuwait Institute for Medical Specialization
Faculty of _____ (KIMS)



EDUCATION		
SECONDARY SCHOOL	NAME OF SCHOOL	DATE OF GRADUATION
UNIVERSITY EDUCATION	DEGREE & UNIVERSITY	YEAR OF GRADUATION
POST GRADUATION	DEGREE	DATE

.....: الاسم باللغة العربية
.....: Name
.....: Nationality
.....: Date of Birth
.....: Sex
.....: Marital Status
.....: Date of Appointment
.....: Residence Tel. No.
.....: Mobile Tel. No.

BASIC TRAINING

FIRST YEAR

HOSPITAL :
DEPARTMENT:
UNIT :
PERIOD : from : to:
HOSPITAL :
DEPARTMENT:
UNIT :
PERIOD : from : to:

HOSPITAL :
DEPARTMENT:
UNIT :
PERIOD : from : to:
HOSPITAL :
DEPARTMENT:
UNIT :
PERIOD : from : to:

SECOND YEAR

HOSPITAL	SPECIALITY	PERIOD	ASSESSMENT

ADDITIONAL EXPERIENCE

HOSPITAL	SPECIALITY/UNIT	DATE (From:-to:)	REMARKS

Present Position (Name of post and hospital)

Have you applied for any of the specialty courses of KIMS before? Yes No

IF yes, which program ?

The Date

The Outcome

Did you sit for any of the specialty examinations of KIMS previously? Yes No

IF yes, which exam ?

The Date

The Outcome

Any other relevant information?

.....

.....

.....

.....

Name & Address of three referees:-

Name: Name: Name:

.....

.....

Tel No:..... Tel No: Tel No:

أقر بأن المعلومات المدونة أعلاه صحيحة.

I undertake that all the information mentioned above are accurate.

التوقيع
Signature

التاريخ
Date