Kuwait Dental Licensing Examination

KUWAIT INSTITUTE FOR MEDICAL SPECIALIZATION

APPLICATION FORM

1. Examination: Date ..... Month February/June/ October Year .....

2. Name: ....
(first) (middle) (family)

3. Nationality: ..... 4. Sex. Male/Female

5. Civil ID No.: ..... 6. Date of Birth: .....

7. Mailing Address: .....
.....
.....

8. Telephone No.: Home ..... Work: ..... Mobile : .....

9. Fax No.: ..... 10. Email address.....

11. Dental qualifications:

	Undergraduate	Postgraduate
Degree (eg. BDS)	.....	.....
Year obtained	.....	.....
University/College	.....	.....
Country	.....	.....

12. Present employment: Trainee/Assistant Registrar/Registrar/Senior Registrar/Specialist
Department .....
Hospital .....

13. Signature: ..... Date: .....

NOTE

1. Please supply 2 recent passport size photos with application.
2. Please make sure you enclose the full payment. (50 Kuwaiti Dinar).
3. Applications must be received no later than 6 weeks before the date of the examination.
4. Late applications will not be accepted.
5. Payment for the examination will not be refunded.
6. Please submit your application at the KMLE/KDLE office, 8th Floor, Behbehani Complex, Al-Sharq.

For Office Use Only

1. Date application received: .....
2. Examination date: February/June/October
3. Payment received: Yes/No

Application approved: Yes/No

Examination Number: ..... Signed .....
Director