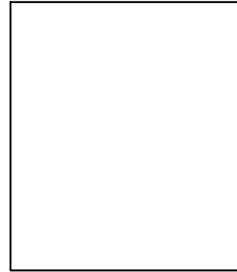
DEPARTMENT OF HEALTH, SABAH
KOTA KINABALU, SABAH, MALAYSIA.

APPLICATION FORM FOR MEDICAL ELECTIVE



FIRST NAME : ……………………………………………………………………

LAST NAME :……………………………………………………………………

NATIONALITY :……………………………………………………………………

SEX: [ ] MALE [ ] FEMALE

DATE OF BIRTH :……………………………………………………………………

PASSPORT NUMBER : …………………………………………… EXPIRY DATE :…………………………………

MAILING ADRESSED :……………………………………………………………………………………………..

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TEL:……………………………………………………………………………………………...

e-mail ADDRESS : ……………………………………………………………………………………………………

PERMANENT ADDRESS : ………………………………………………………………………………………..

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MEDICAL SCHOOL ADDRESS :……………………………………………………………………………....

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LANGUAGES SPOKEN : ………………………………………………………………………………………..

LENGTH ELECTIVE AND DATES :…………………………………………………………………………………..

STATE YOUR PREFERENCE OF DEPARTMENT (AND SUBSPECIALITY IF APPLICABLE) :…………………...

………

AND / OR : ………...

SIGNATURE:………………………………………………

DATE : ………………………………………………

PLEASE ENCLOSE:

1) LETTER OF ENDORSEMENT FROM YOUR MEDICAL SCHOOL
2) CURRICULUM VITAE
3) TWO PHOTOGRAPHS
4) A COVERING LETTER INDICATING WHY YOU WISH TO DO AN ELECTIVE AT THIS HOSPITAL

For Office Use Only			
Discipline	Date	Supervisor	Hospital

Signature:
Name :
Date :