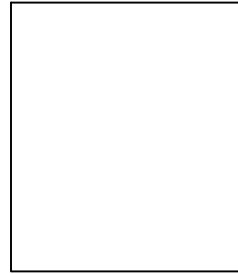


**DEPARTMENT OF HEALTH, SABAH
KOTA KINABALU, SABAH, MALAYSIA.**

APPLICATION FORM FOR MEDICAL ELECTIVE



FIRST NAME :

LAST NAME :

NATIONALITY :

SEX: MALE FEMALE

DATE OF BIRTH :

PASSPORT NUMBER : EXPIRY DATE :

MAILING ADRESSED :

.....

.....

TEL:

e-mail ADDRESS :

PERMANENT ADDRESS :

.....

.....

MEDICAL SCHOOL ADDRESS :

.....

.....

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 :