مركز التخطيط والجودة للخدمات الطبية
CENTER FOR HEALTHCARE PLANNING & QUALITY

Application for Allied Health Professional License

Exclusive licensure for practicing in Dubai Healthcare City

☐ **Operator sponsoring application (indicate name):** _____

☐ **No operator (Please notify "Licensing Department when you start work at DHCC)**
Please seek "Letter of Acceptance" information from Professional Licensing, CPQ.

Please check box that applies:

☐ Audiologist	☐ Hair Transplant Tech	☐ Perfusionist	☐ Prothetist
☐ Cardiovascular Tech	☐ Medical Laboratory Tech	☐ Pharmacist	☐ Psychologist
☐ Clinical Embryologist	☐ Nutritionist	☐ Physical Therapist	☐ Radiology Tech
☐ Dental Hygienist	☐ Occupational Therapist	☐ Physician Assistant	☐ Respiratory Therapist
☐ Dental Tech	☐ Optometrist	☐ Podiatrist	☐ Psychologist
☐ Emergency Medical Tech			

Other (please specify): _____

ALL FIELDS ARE MANDATORY

Please type or print clearly in ENGLISH LANGUAGE

1. Name: *Please enter your complete name and any maiden/previous name as per passport.*

LAST NAME: _____

FIRST AND MIDDLE NAME(S): _____

MAIDEN NAME(S): _____

PREVIOUS NAME(S): _____

2. Contact Information: *Please provide ONE mailing address only.*

STREET ADDRESS/POST OFFICE BOX: _____

_____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ MOBILE NUMBER: _____

FACSIMILE NUMBER: _____ E-MAIL ADDRESS 1: _____

E-MAIL ADDRESS 2: _____

3. Date and Place of Birth: *Please enter your date and place of birth.*

DAY: _____ MONTH: _____ YEAR: _____

4. Gender: *Please check one.*

☐ MALE ☐ FEMALE

5. Identification Details: *Please fill in the details.*

PASSPORT NUMBER: _____ COUNTRY OF ISSUE: _____

EXPIRY DATE: _____

6. Languages Spoken: *Please fill in the details.*

☐ ARABIC ☐ ENGLISH OTHERS: _____ _____

7. Have you ever applied for an Allied Health Professional License to Practice in DHCC? ☐ ***YES*** ☐ ***NO***

If yes, please list DHCC License Number: _____

8. License/Registration: *Please list all jurisdictions in which a license to practice has been obtained. Include permanent, limited, and other special purpose licenses or registrations.*

FULL NAME OF LICENSING/REGISTRATION JURISDICTION: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____

LICENSE/ REGISTRATION CATEGORY: _____

LICENSE/REGISTRATION NUMBER: _____

LICENSE ISSUE DATE (MM/YY): _____ LICENSE EXPIRATION DATE (MM/YY): _____

LICENSE REGISTRATION STATUS (CHECK ONE):

☐ ACTIVE ☐ INACTIVE ☐ SUSPENDED ☐ REVOKED

If the license/registration is suspended or revoked, please provide information

Other Jurisdiction(s) Where A License/Registration Was Obtained (if applicable)

FULL NAME OF LICENSING/REGISTRATION JURISDICTION: _____

STREET ADDRESS/POST OFFICE BOX, CITY: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

EMAIL ADDRESS: _____WEBSITE ADDRESS: _____

LICENSE/ REGISTRATION CATEGORY: _____

LICENSE/REGISTRATION NUMBER: _____

LICENSE ISSUE DATE (MM/YY): _____ LICENSE EXPIRATION DATE (MM/YY): _____

LICENSE REGISTRATION STATUS (CHECK ONE):

☐ ACTIVE ☐ INACTIVE ☐ SUSPENDED ☐ REVOKED

If the license/registration is suspended or revoked, please provide information

If additional sheet(s) listing other jurisdictions are enclosed, please check:
☐ ADDITIONAL SHEET(S) ENCLOSED

***9. Language Proficiency:** Please enter the language of your Allied Health Education.*

WAS ENGLISH THE LANGUAGE OF INSTRUCTION FOR YOUR ALLIED HEALTH PROGRAM? ☐ YES ☐ NO

IF NO, WHAT WAS THE LANGUAGE OF INSTRUCTION? _____

IF ENGLISH WAS NOT THE LANGUAGE OF INSTRUCTION OF YOUR ALLIED HEALTH PROGRAM, HAVE YOU EVER TAKEN THE TOEFL EXAM?

☐ YES ☐ NO

IF YOU HAVE TAKEN THE TOEFL EXAM,

WHEN: _____ WHERE: _____SCORE: _____

ORGANIZATION/INSTITUTE WHO ADMINISTERED THE EXAM: _____

***10. Secondary Schooling:** This section must be filled by those applicants who have not obtained a Bachelor degree in their respective allied health professional.*

NAME OF SECONDARY SCHOOL: _____

DATE OF GRADUATION FROM SECONDARY SCHOOL (MM/YY): _____

11. University/School: *Please list all university/schools attended not just the one from which you graduated.*

FULL NAME OF UNIVERSITY/SCHOOL: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

ATTENDED FROM (DD/MM/YY): _____ TO (DD/MM/YY): _____

GRADUATION DATE (MM/YY): _____ DEGREE OBTAINED: _____

NAME AT GRADUATION: _____

Other University(s)/School(s) Attended

FULL NAME OF UNIVERSITY/SCHOOL: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

ATTENDED FROM (DD/MM/YY): _____ TO (DD/MM/YY): _____

GRADUATION DATE (MM/YY): _____ DEGREE OBTAINED: _____

NAME AT GRADUATION: _____

If additional sheet(s) listing other universities/schools attended are enclosed, please check:

☐ ADDITIONAL SHEET(S) ENCLOSED

12. Postgraduate Education: *Please list all healthcare related postgraduate education obtained after graduation from University/School.*

FULL NAME OF UNIVERSITY/SCHOOL: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

ATTENDED FROM (DD/MM/YY): _____ TO (DD/MM/YY): _____

GRADUATION DATE (MM/YY): _____ DEGREE OBTAINED: _____

NAME AT GRADUATION: _____

Other University(s)/School(s) Attended

FULL NAME OF UNIVERSITY/SCHOOL: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

ATTENDED FROM (DD/MM/YY): _____ TO (DD/MM/YY): _____

GRADUATION DATE (MM/YY): _____ DEGREE OBTAINED: _____

NAME AT GRADUATION: _____

If additional sheet(s) listing other universities/schools attended are enclosed, please check:

☐ ADDITIONAL SHEET(S) ENCLOSED

13. Professional Membership/Affiliations: *Please provide a summary of your professional membership/affiliation activities since completion of your education*

FULL NAME OF INSTITUTION/ASSOCIATION: _____

STREET ADDRESS/POST OFFICE BOX: _____

CITY: _____ STATE/PROVINCE: _____

COUNTRY: _____ POSTAL/ZIP CODE: _____

TELEPHONE NUMBER: _____ FACSIMILE NUMBER: _____

WEBSITE ADDRESS: _____

MEMBERSHIP/AFFILIATION FROM (MM/YY):_____ TO (MM/YY): _____

If additional sheet(s) listing other institutions attended are enclosed, please check:

☐ ADDITIONAL SHEET(S) ENCLOSED

14. Work Experience: *Please provide a summary of your professional practice for at least the last ten (10) years (if applicable).*

APPOINTMENT/POSITION/TITLE	NAME AND ADDRESS OF INSTITUTE OF PRACTICE	CLINICAL DEPARTMENT/AREA OF PRACTICE	FROM (D/M/Y)	TO (D/M/Y)

15. Additional Questions: *Please answer the following questions.*

HAVE YOU EVER BEEN SUED OR BEEN INVOLVED IN ANY MALPRACTICE OR MEDICAL NEGLIGENCE LITIGATION IN THE LAST TEN (10) YEARS?

☐ YES ☐ NO

DO YOU CARRY MALPRACTICE INSURANCE?

☐ YES ☐ NO

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL CHARGE?

☐ YES ☐ NO

DO YOU SUFFER, OR HAVE YOU SUFFERED IN THE PAST, ANY PHYSICAL OR MENTAL DISABILITY THAT MAY IMPAIR YOUR ABILITY TO PRACTICE MEDICINE?

☐ YES ☐ NO

HAS ANY DISCIPLINARY ACTION EVER BEEN TAKEN AGAINST YOU FOR VIOLATION OF LAWS, RULES, BY-LAWS, OR STANDARDS OF PRACTICE BY ANY GOVERNMENT AUTHORITY, HEALTHCARE FACILITY, GROUP PROFESSIONAL MEDICAL SOCIETY OR ASSOCIATION IN ANY JURISDICTION?

☐ YES ☐ NO

WITHIN THE PAST TWO (2) YEARS, HAVE YOU ENGAGED IN THE USE OF CHEMICAL SUBSTANCES WITH THE RESULT THAT YOUR ABILITY TO PRACTICE MEDICINE IS CURRENTLY IMPAIRED OR LIMITED?

☐ YES ☐ NO

HAVE YOU EVER REFUSED TO SUBMIT TO A TEST TO DETERMINE WHETHER YOU HAD CONSUMED AND/OR WERE UNDER THE INFLUENCE OF CHEMICAL SUBSTANCES?

☐ YES ☐ NO

All information will be subject to DHCC Laws of Confidentiality.

16. Documentation Checklist: Please submit the following.

☐ COMPLETED APPLICATION (All applicable information's should be completed in ENGLISH)

☐ TWO (2) PASSPORT-SIZED PHOTOS

☐ COMPLETED AFFIDAVIT AND RELEASE - Page 11

☐ COMPLETED AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS - Page 12

☐ **TWO (2) COPIES EACH**, INCLUDING CERTIFIED ENGLISH TRANSLATIONS IF ORIGINAL DOCUMENTS ARE NOT IN ENGLISH, OF:

- PASSPORT (to include image, signature and number)
- ALLIED HEALTH LICENSE/REGISTRATION (authenticated copy is required)
- ALLIED HEALTH DEGREES/DIPLOMA (authenticated copy is required)
- SCHOOL TRANSCRIPTS FROM YOUR ALLIED HEALTH PROGRAM OF STUDY
- IF APPLICABLE
  - POSTGRADUATE DEGREES/DIPLOMAS/CERTIFICATES (authenticated copy(s) is required)
  - BOARD/COLLEGE/ASSOCIATION CERTIFICATES (authenticated copy(s) is required)
  - BLS/ACLS CERTIFICATES
  - MEDICAL MALPRACTICE INSURANCE (If applicable)

NOTE: *ALL EDUCATIONAL DOCUMENTS MUST BE VERIFIED AND AUTHENTICATED BY THE ISSUING UNIVERSITY/COLLEGE/SCHOOL.*

☐ CURRICULUM VITAE

☐ TWO LETTERS OF RECOMMENDATION, ONE EACH FROM A PROFESSIONAL COLLEAGUE WHO HAS WORKED WITH YOU IN THE PAST FIVE (5) YEARS. ONE OF THE LETTERS MUST BE WRITTEN BY A COLLEAGUE WHO IS EMPLOYED IN A SUPERVISOR CAPACITY (EXCLUDING RELATIVES). THESE REFERENCES SHOULD ADDRESS MORAL AND ETHICAL CHARACTER AND COMPETENCIES TO PRACTICE HEALTHCARE.

☐ OFFICIAL EMPLOYMENT LETTER FOR THE LAST FIVE (5) YEARS.

☐ APPLICATION FEES (once submitted, fees will NOT be refundable for any reason).

☐ TOEFL EXAM RESULTS (if applicable)

NOTES TO CONSIDER:

- ***YOU ARE REQUIRED TO SUBMIT A COPY OF YOUR BASIC LIFE SUPPORT (BLS) AS A MINIMUM TO COMMEMCE PRACTICE AFTER APPROVAL. HEALTHCARE PROFESSIONALS SUCH AS ANESTHESIOLOGISTS, PARAMEDICS, ETC ARE REQUIRED TO HAVE CERTIFICATION IN ACLS AS A MINIMUM.***

- ***APPLICANTS ARE REQUIRED TO IMMEDIATELY NOTIFY PROFESSIONAL LICENSING DEPARTMENT, CENTER FOR HEALTHCARE PLANNING AND QUALITY (CPQ) OF ANY CHANGES OR NEW INFORMATION RELATED TO THE APPLICATION.***

- ***ALL MATERIALS SENT AS PART OF THIS APPLICATION PROCESS WILL BE RETAINED BY CPQ LICENSING DEPARTMENT AND WILL NOT BE RETURNED TO THE APPLICANT.***

- ***UPON REVIEW OF THIS APPLICATION, AN INTERVIEW MAY BE REQUESTED. IN ADDITION, CPQ LICENSING DEPARTMENT RESERVES THE RIGHT TO ACCEPT OR DENY ANY APPLICANT FOR DHCC LICENSURE AT ITS SOLE DISCRETION.***

ACKNOWLEDGEMENT:

- ***I HEREBY CONFIRM THAT THE ABOVE INFORMATION IS TRUTHFUL AND AUTHORIZE CPQ LICENSING DEPARTMENT TO CONTACT MY UNIVERSITIES, HOSPITALS, TRAINING PROGRAMS, AND REFERENCES FOR PURPOSES OF PRIMARY SOURCE VERIFICATION.***

- ***PLEASE NOTE BY SIGNING THIS FORM "I ACKNOWLEDGE THAT INFORMATION ABOUT ME RELEVANT TO MY PRACTICE MAY BE MADE PUBLIC; I AM AWARE OF THE REQUIREMENT ON ME TO REPORT TO THE COMPLAINT UNIT ANY HEALTHCARE PROFESSIONAL WHO IS IMPAIRED OR DISABLED FOR WHATEVER REASON AND WHO'S IMPAIRMENT CONSTITUTES A PUBLIC RISK."***

_____ _____

SIGNATURE **DATE (DAY/MONTH/YEAR)**

PRIMARY SOURCE VERIFICATION

As part of the Application for Professional License to Practice in Dubai Healthcare City (DHCC), certain credentials must be verified for authenticity. These credentials include, at the minimum, medical school degrees/diplomas, medical school transcripts, medical license/registration certificates in other jurisdictions, postgraduate training certificates and board certification. Professional Licensing at the Center for Healthcare Planning and Quality (CPQ) will obtain primary source verification for the authenticity of these documents from the source/s that issued them.

Professional Licensing will submit copies of your documents to be verified to the respective authorities to secure primary source verification of submitted credentials. Professional Licensing will request that an authorized institution official complete the verification request form and return it directly to CPQ. If Professional Licensing does not receive verification of a document within the set target timeline then the application will become inactive.

In order to begin this process, the Professional Licensing requires that applicants complete the Affidavit and Release (Page 11) and the Authorization for Release of Information, Documents, and Records (Page 12) forms that are attached.

The PSV performed by Professional Licensing is a verification intended for DHCC Licensure. This is a report of authenticity of the presented documents. Once verified, your credentials will be evaluated by Professional Licensing and the DHCC Licensing Board for review and decision.

_____ _____

Signature Date (Day/Month/Year)

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make on or in connection with the application are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies I furnish with my application are true and correct.

I acknowledge that I have read and understood the application form and have answered all questions contained in it truthfully and completely.

I authorize every person, medical school, university, hospital, clinic, government agency, or institution having custody or control of any documents, records, and other information pertaining to me to furnish to the Professional Licensing, CPQ any such information, or true and correct copies of documents or records.

I hereby release, discharge, and hold harmless Professional Licensing, CPQ, its employees, agents, or representatives, and any person furnishing information, records, or documents of any and all liability. I authorize the Professional Licensing, CPQ to release information, material, documents, orders, or the like relating to me or this application to other entities or third party at my request.
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_____
Applicant's Signature (must be signed in the presence of a notary public, consular official, or first class magistrate)

_____
Applicant's printed last name, first name, middle initial, suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

Attach one current full-face photo here. Use tape or glue; no staples, please.

Sign across the bottom or top of the photo. Do not sign at the back.

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this individual by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the individual and with the photograph affixed hereto, and (b) comparing the individual's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn before me by the individual on this _____ day, in the month of _____, in the year _____

X

_____
Signature of Consular Official, First Class Magistrate, Notary Public (in Latin characters with English translations, where applicable.)

_____
Official Title

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, the undersigned, hereby authorize the Professional Licensing, CPQ to collect, verify, and maintain information and copies of documents and records in support of my Application for Professional License for Practice in Dubai Healthcare City.

I request and authorize every person, medical school, university, institution, professional licensing board, hospital, clinic, government agency, or other third parties and organizations and their representatives to release information, records, diplomas, transcripts, and other documents concerning my professional education, qualifications, experience and competence, ethics, character, and other information pertaining to me to the Professional Licensing, CPQ. I further request and authorize that the requested information, records, diplomas, transcripts, and other documents be sent directly to the Professional Licensing, CPQ.

Immunity and Release

I hereby extend absolute immunity to, and release, discharge, and hold harmless from any and all liability: (1) Professional Licensing, CPQ, its employees, agents, representatives, directors, and officers; (2) other agencies, medical schools, universities, institutions, hospitals, and clinics providing information, their employees, representatives, directors, and officers; and (3) any third parties and organizations for any acts, communications, reports, records, diplomas, transcripts, statements, documents, recommendations, or disclosures involving me, made in good faith and without malice, requested and received by the Professional Licensing, CPQ. I understand that Professional Licensing, CPQ will not accept such information, records, or documents forwarded by me.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid from the date signed.

_____
Signature

_____
Date of signature

_____
Printed last name, first name, middle initial, suffix (e.g., Jr.)

_____
Date of birth (day, month, and year)

Attach one current full-face photo here. Use tape or glue; no staples, please.

Sign across the bottom or top of the photo. Do not sign at the back.

Mailing Addresses:

Please mail/submit your completed application to:

For mail delivery:

Licensing Department – Professional Licensing
Centre for Planning and Quality (CPQ)
Dubai Healthcare City
P.O. Box 505001
Dubai
United Arab Emirates Tel: +971-4-362-2790
Fax: +971-4-362-4770

For courier delivery:

Licensing Department – Professional Licensing
Centre for Planning and Quality (CPQ)
Ibn Sina Building, Block B, Ground Floor
Dubai Healthcare City
Oud Metha Road
Dubai
United Arab Emirates Tel: +971-4-362-2790
Fax: +971-4-362-4770

For email:

Email: info@cpq.dhcc.ae
Attention: Licensing Department - Professional Licensing
Centre for Planning and Quality (CPQ)