



Surgical/Dental Privileges Application Form

Registration and Licensing

Personal Details

First Name: _____ Middle Name: _____ Last Name: _____

(Please fill name as given in passport.)

Date of Birth: _____ Gender: Male Female

Nationality: _____

Mobile Phone: _____ Work Phone: _____

P. O. Box: _____ Email address: _____

<input type="checkbox"/>	<input type="checkbox"/>
Public Sector	Private Sector
<input type="checkbox"/>	<input type="checkbox"/>
Qatari	Non-Qatari

Submitted by:

Name of Employer: _____

Signature of Employer: _____

Date: _____

Scope of Practice

Physician

Please specify your specialty:

Dentist

Details of Medical License in Qatar or Details of Evaluation

License No.: _____

Evaluation Request No.: _____

Place of Work: _____

Scope of Practice: _____

Has any disciplinary action been taken against you because of violations related to your profession?

Yes

No

If yes, explain:

Name of Applicant: _____

Date: _____ Signature: _____