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: ____________

☐ Public Sector ☐ Private Sector

☐ Qatari ☐ Non-Qatari

Submitted by:

Name of Employer: ____________

Signature of Employer: ____________

Date: ____________

Scope of Practice

Physician ☐

Dentist ☐

Please specify your specialty: ____________

Details of Medical License in Qatar or Details of Evaluation

License No.: ____________

Evaluation Request No.: ____________

Place of Work: ____________

Scope of Practice: ____________

Name of Applicant: ____________

Date: ____________ Signature: ____________

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

☐ Yes
☐ No

If yes, explain: ____________

Tel: +974 4407 0319 / 0366 / 0340 P.O Box: 7744. Doha – Qatar https://dhp.moph.gov.qa