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 :