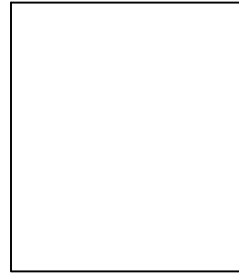


**DEPARTMENT OF HEALTH, SABAH  
KOTA KINABALU, SABAH, MALAYSIA.**

**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 :