Kingdom of Bahrain – Ministry of Health
Family Practice Residency Program

Application Form

1. Full Name: _____

2. Date of Birth: _____ C.P.R. _____

3. Sex: Male / Female _____ Nationality: _____

4. Passport No._____ Date of Issue: _____

5. Current Address: House/Building: _____ Road: _____ Block: _____
   Region: _____ P.O. Box: _____ Telephone No.: _____
   Mobile: No. _____ Fax No.: _____
   E-mail Address: _____

6. Martial Status: _____ No. of Children: _____

7. Next of Kin: Name: _____
   Relationship: _____ Tel/Mobile No.: _____
   Address: _____

8. University of Graduation: _____
   Country: _____ Certificate Title: _____
   Grade: _____ Study Period from: _____ To: _____

9. Internship: From: _____ To: _____

   Hospital: _____

10. Date of Passing the Licensure Exam:_____ No. of Attempts: ___

11. Service date for MOH employee:_____

12. Post Graduate Experience:_____ Period: _____

13. Hobbies & Special Skills:_____

    _____

14. Special Honor, Societies, Memberships:_____

    _____

15. Computer Literacy:_____

16. Any research done? If yes ... Title: _____

    _____

17. Primary Care Experience:_____

18. Knowledge of Languages:

    A. Arabic _____ B. English _____C. Other:_____

19. Name of Bank: _____ Account No.: _____

20. Department / Specialty applied for: (Mention three choices in the order of preference):

    1. _____

    2. _____

    3. _____

Note: Please fill page No. 4 of this application.

Prerequisites for application:

- Bahraini Nationality
- Completion of Internship Program
- Completion of Bahrain Medical Licensure Examination
- Completion of Bachelor degree in Medicine.
- Recognition/Accreditation of the degree by the Ministry of Education.

Application should be submitted to the office of the Family Practice Residency Program (FPRP)**,** along with the following documents:

- 2 copies of Medical Degree along with 2 copies of transcripts
- 2 copies of Accreditation of the Medical Degree from Ministry of Education
- 2 copies of Internship Certificate, including evaluation
- 2 copies of Bahrain Medical Licensure (BMLE) certificate
- 2 copies of Secondary School Certificate with the final scores
- 4 passport size photographs
- 2 copies of CPR card
- 2 copies of Passport

I, the undersigned, declare that the above mentioned information is correct.
If any is found to be false, the application will not be considered.

_____ _____

Signature **Date**

For further information, please contact our office on the following address:

Family Practice Residency Program
Naim Health Centre –P.O. Box. 42
Ministry of Health –Kingdom of Bahrain

Tel: 17263597 - Fax: 17251104
E-mailfprp@health.gov.bh

Write in brief, why did you choose the Family Medicine as a Career?