

CLEARANCE FORM

Doctor's Name: _____

OMSB No. : ()

Specialty: _____

Date Commenced: _____ Date of Completion/Withdrawal: _____

You are kindly requested to certify that the above mentioned Doctor has fulfilled all his/her obligations to your department. Please ensure that sections below are duly signed and stamped by your department.

Medical Library, Royal Hospital		Medical Library, SQU	
Signature: _____		Signature: _____	
General Services / :	Royal Hospital <input type="radio"/>	SQU <input type="radio"/>	Al Nahdha Hospital <input type="radio"/>
Computer Services	Khoulia Hospital <input type="radio"/>	AFH <input type="radio"/>	ROP <input type="radio"/>
	Ibn Sina Hospital <input type="radio"/>		
<ul style="list-style-type: none"> • De-activate Computer Password <input type="radio"/> • Collect On-Call Room Key, if any <input type="radio"/> 			
Signature: _____			
OMSB Administration Department		E-Library (OMSB - IT Department)	
<ul style="list-style-type: none"> • Collect OMSB ID <input type="radio"/> 		<ul style="list-style-type: none"> • De-activate Password <input type="radio"/> 	
Signature: _____		Signature: _____	

Approval of OMSB Trainee Affairs Department: _____

Date: _____

N.B. No certificate shall be issued without the completion of this form.