

Oman Medical Specialty Board



المجلس العماني للإختصاصات الطبية

Registration Form استمارة تسجيل

Full Name:

Date of Birth: Staff no. :

Passport no.: National ID card no.:

Address:

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Telephone no. (home & mobile)

E-mail Fax

Contact in case of Emergency

Sponsor

Academic Year Program

I declare that all information provided in this form is true, complete and correct to the best of my knowledge and belief. I hereby agree to join OMSB Residency Training Program and I will abide by the bylaws and regulations of the OMSB and training centers.

Resident's Signature:

Date: