



## REQUEST FOR WORK CERTIFICATE

<b>Full Name :</b>	
<b>License. No :</b>	<b>Oman Civil Number:</b>
<b>Designation :</b>	<b>Specialty :</b>
<b>Date of Joining the Private Health Establishments:</b>	
<b>Date of Leaving the Private Health Establishments:</b>	
<b>Reason for Leaving :</b>	
<b>Contact number:</b>	<b>E.mail:</b>

This to be filled by the DG of Private Health Establishments.

1. Has the applicant even been investigated in any medical malpractice?

Yes

No

if yes please specify below:

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2. Is the applicant involved in a case that is in progress of being investigated for medical malpractice?

Yes

No

if yes please specify below:

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### Remarks:

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### Applicant:

I hereby confirm that the information I have provided in this form are true and I take full responsibility for it .

Applicant Signature .....

Date:.....

### For Official Use

DGPHE

Date:

.....

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الرسوم : 20 ريال Fees : 20 Omani Rials	رقم إيصال الدفع التوقيع والختم	20 م / /	تاريخ دفع الايصال اسم موظف مستلم الرسوم
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Documents to be submitted:

- 1- Requested letter from the applicant or place of work to the Directorate General of Private Health Establishments.
- 2- License copy.
- 3- Passport copy.