GENERAL INFORMATION

**Program:** APS Program

Basic  Intermediate

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name\*** | | **Middle Name\*** | | **Last Name\*** |
| *.* |  | *.* |  | *.* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender\*** | | **Nationality\*** | | **Date of Birth\*** |
| Choose an item. |  | *.* |  | *.* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Birth\*** | | **Country of Residence\*** | |  |
| *.* |  | *.* |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Contact Number\*** | | **Email Address\*** | |
| *.* |  | *.* |

|  |  |  |
| --- | --- | --- |
| **Level of Training \*** |  | **Field of Specialty \*** |
| Choose an item. | *.* |

PREFERRED TRAINING DATES

*Please note, you must allow four weeks for application processing. Training dates starting sooner than four weeks from application submission will not be entertained.*

|  |  |  |
| --- | --- | --- |
| **Training Start Date \*** |  | **Training End Date \*** |
| *.* | *.* |

***NOTE: Once trainee is registered in APS program, TRAINING DATES stand final. No change is allowed.***

SPECIALTY OF INTEREST

|  |
| --- |
| **Specialty 1st Choice \*** |
| *.* |

|  |
| --- |
| **Specialty 2nd Choice \*** |
| *.* |

DOCUMENTATION

|  |  |  |
| --- | --- | --- |
| **Passport Copy (Clear & Colored Copy) \*** | **Photo (Passport Size) *(High resolution photo for security requirements)* \*** | **Are you a UAE Resident? \*** |
| Choose file | Choose file | Yes  No |

|  |
| --- |
| **Health Insurance for UAE Residents *Non-UAE residents will need to provide proof of traveller’s insurance if accepted into the program.*** |
| Choose file |

|  |
| --- |
| **Are you currently employed? \*** |
| Yes  No |

|  |
| --- |
| **Employer details\*** |
| *.* |

**Are you a Medical License Holder? \***

|  |  |
| --- | --- |
| **No** | **Yes Please upload a copy of the license\*** |

EDUCATION

|  |
| --- |
| **What is your highest level of education? \*** |
| Choose an item. |

|  |
| --- |
| **Country \*** |
| *.* |

|  |  |  |
| --- | --- | --- |
| **Start Date of highest educational program \*** |  | **End Date \*** |
| *.* | *.* |

|  |
| --- |
| **How did you hear about this APS program \*** |
| *.* |

ADDITIONAL DOCUMENTATION

|  |
| --- |
| **Please upload a copy of your CV / Resume. \*** |
| Choose file  Shape  Description automatically generated with low confidence |

**Please upload a copy of your Letter of Intent (Cover Letter)**

*Provide personal background information, describe why the program at CRH appeals to you, and define what skills and interests you have that would make you a good candidate for this program* \*

|  |
| --- |
| Choose file  Shape  Description automatically generated with low confidence |

**Please provide one (1) Letter of Recommendation.** (*Must be in PDF format*)   
*At least one should be from a direct supervisor, chairman or section head.* **\*OR**

Please provide a Letter of Endorsement from the Dean or Program Director of your institution (if applicable).

The letter of endorsement is meant to signify acknowledgement from your institution that you are applying to an education program at CRH.

|  |
| --- |
| Choose file  Shape  Description automatically generated with low confidence |

AGREEMENT

* INCOMPLETE application will be rejected.
* APS enrolled trainees shall not receive any financial support, worker's compensation, housing, insurance coverage, employment, or other compensation from CRH.
* By submitting this application, the trainee agrees to follow all bylaws, procedures, and policies implemented at CRH.
* Failure to maintain the attendance of 95% during the duration of the APS program will deprive the trainee from the issuance of the training certificate by the Academic Office.
* CRH has the right to terminate an APS program without any prior notice of its sole discretion without any liability. In such a case the trainee agrees to the CRH decision and will not demand any compensation or proceed with any legal action against the organization.

**I AGREE, AND CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS ACCURATE.**

**I ABIDE AND CONFORM TO THE CONFIDENTIALITY OF PATIENT HEALTH INFORMATION POLICY.** \*

Agree

Disagree

|  |  |  |
| --- | --- | --- |
| **Signature \*** |  | **Date \*** |
| *.* | *.* |