Required Documents for Fellowship Training Programs
Academic Year (AY) 2025-2026

- Employer/Sponsor Approval Form for Release and Selection of Training Programs
  - **Form must be signed & stamped by Employer/Sponsor**
- Curriculum Vitae
  - **OMSB Format (Attached)**
- Scanned PDF copy of Completion of Residency Training Certificate
- Scanned PDF copy of Specialty Certificate
  - **If the Specialty Certificate is obtained from outside Oman, it is mandatory to obtain verification and attestation of Specialty Certificate from the Verification & Equivalency of Health Professional Certificates Section at OMSB**
- Scanned PDF copy of valid National Identity Card and Passport
  - **The dual side of the National ID card need to be in PDF document**
- Applicant Health Assessment (AHA) Form (To submit all mentioned test reports within the application period) – (Attached form):
  - **Hepatitis B Serology (HBsAg, Anti-HBc & Anti-HBs)**
  - **Hepatitis C Serology (Anti-HCV)**
  - **HIV (HIV Antigen & Antibody Screening Test)**
  - **Quantiferon-TB Gold**
  - **MMR IgG**
  - **Varicella IgG**
- Photocopy of valid BLS and ACLS/PALS certificates (according to the Residency Training) from the American Heart Association (AHA):
  - **BLS and ACLS/PALS certificates must be valid during the registration period and until the start of the AY 2025-2026 (1st September 2025)**
- Other relevant documents to be uploaded (If applicable)

CURRICULUM VITAE
(FELLOWSHIP)

I. DEMOGRAPHIC INFORMATION SECTION

Name (As per passport): …………………………..………………..……….……………………………..…
Date of Birth: ……..………………………………………………………………………………….…......
Nationality: ……………………………….……… Marital Status: ……...…………..………………………….
National ID No.: ……..........................………. Passport No.: ……..…..............……...................……
Permanent Address: ………………………....……………………...…..............……..………...………...
Wilayat/Region: ……………………………………………………………………………………………
Mobile No.: ………….................................... E-Mail Address: …………………………………………………
Staff No. (if applicable): ……………………………………………………………………………………

Name of Next of Kin (NOK): ……………………....…......……. Contact No. of NOK: ……….......…….

II. QUALIFICATION DATA SECTION

1. Secondary School:

School: ________________________________ From: ________________ To: _______________
Country: _______________________________

2. BSc/Medical School:

Institution: ____________________________ From: ________________ To: ________________
Country: ______________________________

3. Internship:

Department: ____________________________ From: _________________ To: _______________
Hospital: ______________________________
Country: ______________________________

Department: ____________________________ From: _________________ To: _______________
Hospital: ______________________________
Country: ______________________________

Department: _____ From: _____ To: _____

Hospital: _____

Country: _____

4. **Completion of Training Certificate:**

Institution: _____ From: _____ To: _____

Country: _____

5. **Specialty Certificate:**

Institution: _____ Date: _____

Country: _____

6. **Life Support Training Courses:**

- BLS Expiry Date: .....
- ACLS (if applicable) Expiry Date: .....
- PALS (if applicable) Expiry Date: .....

III. SCHOLARLY ACTIVITIES SECTION

1. **Research (if available):**

Project Title: _____

Position: _____ Inclusive Dates: _____

Institution: _____ Department: _____

Mentor: _____

Project Title: _____

Position: _____ Inclusive Dates: _____

Institution: _____ Department: _____

Mentor: _____

2. **Publications (if available):**

Last, First, Middle Initial of authors as listed in the paper. Underline your name. Title of article, Journal, Publication date; vol (issue): pages. (Should include abstracts).

_____

_____

_____

3. **Conferences Presentations (if available):**

Name of Conference, Presentation title, (if 'placed', list here), Date and Location

_____

_____

_____

Name of Conference, Presentation title, (if 'placed', list here), Date and Location

_____

_____

_____

4. **Continuing Professional Development (CPD) Certificates:**

Certificates of credits hours from OMSB CPD Section

_____

_____

_____

5. **Review in Medical Journals (if available)**

Name of Journals: _____

_____

Manuscript Reviewed: _____

_____

6. **Honors and Awards (if available):**

Award, Institution, Date Conferred

_____

_____

_____

7. **Community Service/Volunteer Experience (Health-Related Fields) (if available):**

_____ From: _____ To: _____

_____

_____

_____ From: _____ To: _____

_____

_____

APPLICANT HEALTH ASSESSMENT (AHA) FORM
(ACADEMIC YEAR 2025-2026)

The training history and health assessment provides basis of pre-training evaluation for all applicants joining Oman Medical Specialty Board. Continued postgraduate training contract is dependent on the successful AHA completion.

The purpose of the form is to determine whether you have health conditions that could affect your ability to undertake the duties of the training you have been offered or places you at risk in the workplace. It may be that adjustments or support is recommended as a result of this assessment to enable you to complete your training. Our aim is to promote and maintain the safety and the health of OMSB trainees, patients and staff.

The information that you will provide will be confidential to OMSB and will not be given to anyone else without your written permission. We do use anonymized information for audit purposes, which will not reveal confidential information in any audit report.

The AHA form has two (2) parts to be completed and submitted with your application.

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PART I – Applicant Health Assessment Questions:

No.	Question	Yes/ No
1.	Do you currently have any health condition/impairment/disability (physical or psychological)?	
2.	Have you ever had any health condition/impairment/disability in the past?	
3.	Are you having, or waiting for treatment (including medication) or investigation for any health condition/impairment/disability (physical or psychological)?	
4.	Do you have an infectious disease that can interfere with your work as a clinician?	
5.	Do you need any adjustments or assistance to help you to undergo the training?	

If yes to any of the above questions, please specify details of the condition, treatment and dates. (For more space, please add a separate attachment to this form)

Do you have any additional information related your health? If YES, please specify.

How much time have you lost from work/college due to illness during the last 2 years?

PART II: Follow-up Healthcare Committee (Laboratory Investigation)

Name of Applicant: **Mobile Number:** **National ID:**
Gender: **Date of Birth:**

IMMUNIZATION ASSESSMENT & BLOOD TESTS SECTION	
1	**Vaccination Record/Immunization Report (administered at least 2 doses)** a) MMR: Complete Immunization: ☐ Yes ☐ No b) Varicella: Complete Immunization: ☐ Yes ☐ No Date of Test:
2	**Hepatitis B Serology** a) HBs-Ag: Positive ☐ Negative ☐ b) Anti-HBc: Positive ☐ Negative ☐ c) Anti-HBs (> 10IU/ml): Immune ☐ Non-Immune ☐ Date of Test:
3	**Hepatitis C Serology** a) Anti-HCV: Positive ☐ Negative ☐ Date of Test:
4	**HIV Antigen & Antibody Screening Test** Positive ☐ Negative ☐ Date of Test:
5	**TB Quantiferon-Gold** Positive ☐ Negative ☐ Date of Test:
6	Normal Test ☐ Abnormal Test ☐

Physician Healthcare Officer In-charge:

Name: _____ Signature: _____

Date: _____ Stamp: _____

Immunization records and serology reports should be attached to the Acknowledgment Form with the validity of reports of at least one (1) year upon application to OMSB.

ACKNOWLEDGEMENT

I certify that, to the best of my knowledge and belief, all of the information in this form and/or attached to it, is true, correct, and accurate.

I understand that a false or fraudulent answer to any question or item to any part of this form or its attachments may be grounds for not accepting my registration as an OMSB trainee or for termination from a training program at a later date after acceptance and during my training.

I give consent for my health records to be reviewed, including vaccinations and blood results to be used for assessment by OMSB Follow-up HealthCare committee or other concerned parties, as required.

I understand that any information I give may be investigated for purposes of determining eligibility for OMSB training programs.

I consent to the release of information about my ability and fitness for training by OMSB to authorized personnel or representatives of the OMSB if needed while protecting confidentiality with anonymous processes.

I understand that if any recommendations to my sponsor are necessary as a result of this AHA, OMSB will discuss the recommendations with me, and may disqualify me from joining OMSB.

☐ **I Agree**

Name of Applicant: _____

Date of Birth: _____

National ID Number: _____

Date: _____

Signature: _____