KUMITAT GĦALL-APPROVAZZJONI DWAR SPEĊJALISTI
Our Ref
Your Ref
Communications to be addressed
To THE REGISTRAR

SPECIALIST ACCREDITATION COMMITTEE
Office of the Superintendence of Public Health
Department for Health Regulation
Triq il-Kappillan Mifsud,
Sta Venera SVR 1851,
Malta.
Tel:25953362
E-mail: sac.medical@gov.mt

FORM FOR APPROVAL FOR POSTGRADUATE MEDICAL TRAINING THAT WILL BE HELD ABROAD

Surname_____ Name _____ ID No. _____

MC Reg. No. _____ Country & Institution of Primary Qualification _____

Date of Birth _____ Nationality _____ Gender _____

Address _____

Home Tel. No. _____ Mobile No. _____

E-mail address _____

OTHER INFORMATION

Training Programme 'GP Trainee' _____ 'BST' _____ 'HST' _____

SPECIALITY 1 _____ SPECIALITY 2 _____

Name of the Institution where Specialized Training is being held (other than Malta) _____

Duration of training abroad _____

Date of commencement _____ Expected date of completion _____

Data Protection Statement: All Data collected is processed in accordance with legal provisions, the Data Protection Act (Cap. 586) and the EU Regulation 2016/679 General Data Protection Regulation. Personal Data is not disclosed to third parties if not required by Maltese Law or by other EU obligations.

Signature _____ Date _____

This form is to be returned to the
Registrar
Medical Specialist Accreditation Committee
Office of the Superintendence of Public Health
Department for Health Regulation
Triq il-Kappillan Mifsud,
Sta Venera SVR 1851,
Malta.

Documentation to be submitted with this form

- ID card
- Letter of acceptance from the Officials of the foreign hospital with whom the training will be pursued
- Job description of the training post
- E-mail/letter issued from the Postgraduate training co-ordinator confirming that the training is part of the approved specialization training programme