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|  |  |  |  |
|  | Name: |  |  |
|  | Mobile Number: |  |  |
|  | LinkedIn url |  |  |
|  | Twitter username |  |  |
|  | Medical Registration Number: |  |  |
|  | Roles Considered: |  |  |
|  | Notice Period: |  |  |
|  | Current Employer: |  |  |
|  | Current Position: |  |  |
|  | Current Location: |  |  |
|  | Specialist fields considered: |  |  |
|  | Nationality: |  |  |
|  | Locations preferred: |  |  |
|  | Visa and work permit Required: |  |  |
|  | Hospitals you Applied to Recently: |  |  |
|  | Hospitals you will not work for: |  |  |
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| **Summary of Professional Experience** | | | | | |
| *Job Title* | *Department* | *Months in post* | *Year* | *Name of Employer* | *Country* |
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| **Clinical Skills** | | | |
| *Please list your clinical skills below* | | | |
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| **Education** | | |
|  | | |
| *Higher Qualification/*  *Degree/Diploma with Average obtained* | *Name of the Awarding Body* | *Date of Qualification*  *(DD/MM/YY)* |
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| Gaps in employment *Please list all the gaps in your employment and add a short explanation on them.* | |
|  | |
| Employment HistoryBegin with your most recent or current appointment and then list all previous appointments | |
| **Current employer** | |
| Facility: |  |
| Date: |  |
| Position Title: |  |
| Department: |  |
| Duties & Responsibilities: |  |

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| **Previous employers** | |
| Facility: |  |
| Date: |  |
| Position Title: |  |
| Department: |  |
| Duties & Responsibilities: |  |
|  | |
| Facility: |  |
| Date: |  |
| Position Title: |  |
| Department: |  |
| Duties & Responsibilities: |  |
|  | |
| Facility: |  |
| Date: |  |
| Position Title: |  |
| Department: |  |
| Duties & Responsibilities: |  |
|  | |
| Facility: |  |
| Date: |  |
| Position Title: |  |
| Duties & Responsibilities: |  |
|  | |
| Facility: |  |
| Date: |  |
| Position Title: |  |
| Department: |  |
| Duties & Responsibilities: |  |
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| Facility: |  |
| Date: |  |
| Position Title: |  |
| Department: |  |
| Duties & Responsibilities: |  |

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| Volunteer work |
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| **GMC Medical Council Registration** | |
| *Doctors must be registered with the Irish Medical Council to take up the respective positions.* | |
| Are you registered with the GMC; **YES/NO** |  |
| **If YES**, GMC Registration or Reference Number |  |
| Expiry Date: |  |

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| **Medical Council Registrations** | |
| Are you registered with any other Medical Council: |  |
| **If YES**, Please state the Medical Council Registration or Reference Number |  |
| Expiry Date: |  |

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| Research/Presentations/Publications/Audits | | | | | |
| Please provide details including numbers, subject and date | | | | Date | |
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| **Referees** | | | | | | |
| Name | Job Title | Hospital & Address | Email Address | | Telephone number | |
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