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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: |  |
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| 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: |  |
|  |
| 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 |
|  |  |
| **Referees**  |
| Name | Job Title | Hospital & Address  | Email Address  | Telephone number |
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