

Individual Trainee Registration Form

You **must** complete all registration fields and submit the necessary documents.

PERSONAL INFORMATION (TO BE FILLED BY APPLICANT)

NAME	(First)		GENDER	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	Attach a photo (4x6)
	(Middle)			CONTACT NUMBER		
	(Last)			SAUDI ID/IQAMA NUMBER		
NATIONALITY		SAUDI ID/IQAMA EXPIRY DATE				
DOB (DD/MM/YYYY)		START DATE	___ / ___ / 20___			
EMAIL		END DATE	___ / ___ / 20___			
UNIVERSITY				COUNTRY		
FIELD	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Allied Health <input type="checkbox"/> Pharmacy <input type="checkbox"/> Nursing			CATEGORY	<input type="checkbox"/> STUDENT <input type="checkbox"/> INTERN <input type="checkbox"/> CLINICAL ATTACHMENT	
SPECIALITY						

TRAINING OUTLINE

Training Objective "Please outline the training objectives that must be achieved by the conclusion of the training period."

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Training Rotation "Please detail the training rotation, specifying required department."

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TRAINING SITE

<input type="checkbox"/> Prince Mohammed Bin Abdulaziz Hospital	<input type="checkbox"/> King Fahad Medical City (Allied Health & Nursing)	<input type="checkbox"/> King Salman Center for Kidney Diseases
<input type="checkbox"/> Al Yamama Hospital	<input type="checkbox"/> King Khaled Hospital in Al Majmaa	<input type="checkbox"/> Al Zulf General Hospital
<input type="checkbox"/> Hotat Al Sudeir Hospital	<input type="checkbox"/> Rumah General Hospital	<input type="checkbox"/> Tumier General Hospital
<input type="checkbox"/> Al Artawiyeh General Hospital	<input type="checkbox"/> Al Ghat General Hospital	

Should the program be unavailable at the selected training sites, the coordinator will contact you to explore alternative options.

Please review the following statements and tick the box to indicate your comprehension.

- ☐ I hereby confirm the accuracy of the information provided in my application.
- ☐ I affirm my commitment to fulfilling the required financial obligations when required prior to receiving the end-of-training certificate.
- ☐ I acknowledge my responsibility to complete all registration requirements as stipulated by the Riyadh Second Health Cluster.
- ☐ I consent to abide by all training rules and regulations established by the Riyadh Second Health Cluster.

FULL NAME:

APPLICANT SIGNATURE:

DATE:

Registration forms and supporting documents must be uploaded to the registration platform no later than four weeks prior to the training program's commencement date. For enquires email: support@peg.app

