Armed Forces Hospital King Abdulaziz Air Base
P.O. Box 570, Dhahran 31932
Kingdom of Saudi Arabia

Recruitment Services Section
E-mail: hr.afhdh@gmail.com
Tel.no.: 966-13-330 1000
Fax no.: 966-13-330 25 84

DATE: _______________ **REFERENCE NO.:**____________

RECRUITMENT TYPE: Permanent / Locum

POSITION APPLIED FOR: ____________________________

AREA OF SPECIALITY: ______________________________

AVAILABILITY: _____________________________________

RECENT PHOTO

A. PERSONAL DATA: (Please write clearly and neatly, using block capitals)

FIRST NAME: ___________________________________

SECOND NAME: _________________________________

FAMILY NAME: _________________________________

THIRD NAME: __________________________________

GENDER: ______________________________________

NATIONALITY: __________________________________

RELIGION: _____________________________________

DATE OF BIRTH: ________________________________

PLACE OF BIRTH: _______________________________

AGE: ____

MARITAL STATUS: _______________________________

NO. OF DEPENDENTS: ____________________________
(Under 18 years of age)

HEIGHT: ________________ **WEIGHT:** _______________

LAST DATE OF EMPLOYMENT:

ARE YOU CURRENTLY EMPLOYED: YES / NO

DATE LEFT LAST EMPLOYMENT: _____/_____/______

POINT OF HIRE: __________________________________

E-MAIL: ____

PERMANENT ADDRESS:

BUILDING NO. ____________ **APART. NO.:** __________

STREET: ____

DISTRICT: _______________________________________

P.O.BOX: ________________ **ZIP CODE:** _____________

CITY: ____

COUNTRY: _______________________________________

CONTACT NUMBER'S
(include country & area codes)

HOME NO.: _______________________________________

WORK NO.: _______________________________________

FAX NO.: ____

MOBILE NO.: _____________________________________

PASSPORT NO.: ___________________________________

DATE OF ISSUE: ___________________________________

DATE OF EXPIRY: __________________________________

PLACE OF ISSUE: __________________________________

B. EDUCATION (Please attach copies of all educational papers/documents listed below)

COLLEGE/UNIVERISTY	FROM (month/year)	TO (month/year)	QUALIFICATION
______________________	________	________	________________
______________________	________	________	________________
______________________	________	________	________________
JOB RELATED COURSE	**FROM (month/year)**	**TO (month/year)**	**QUALIFICATION**
______________________	________	________	________________
______________________	________	________	________________
______________________	________	________	________________
PROFESSIONAL TRAINING/MEMBERSHIP	**FROM (month/year)**	**TO (month/year)**	**DETAILS**
______________________	________	________	________________
______________________	________	________	________________
______________________	________	________	________________
PREOFESSIONAL LICENSING BODY	**FROM (month/year)**	**TO (month/year)**	**REGISTRATION (PIN) NUMBER**
______________________	________	________	________________
______________________	________	________	________________

C. REFERENCES (Current or recent employer first and indicate whether contact can be made without your consent)

1. NAME: ______________________ JOB TITLE: ______________________ PROFESSIONAL RELATIONSHIP: __________ EMAIL: ______________________	ADDRESSES INCLUDE PHONE & FAX CONTACT NO. ______________________ ______________________ CONSENT: ________YES ________NO
2. NAME: ______________________ JOB TITLE: ______________________ PROFESSIONAL RELATIONSHIP: __________ EMAIL: ______________________	ADDRESSES INCLUDE PHONE & FAX CONTACT NO. ______________________ ______________________ CONSENT: ________YES ________NO

3. NAME: ______________________________	ADDRESSES INCLUDE PHONE & FAX CONTACT NO.
JOB TITLE: ______________________________	______________________________
PROFESSIONAL RELATIONSHIP: ______________	______________________________
EMAIL: ______________________________	CONSENT: ____________YES ___________NO
4. NAME: ______________________________	ADDRESSES INCLUDE PHONE & FAX CONTACT NO.
JOB TITLE: ______________________________	______________________________
PROFESSIONAL RELATIONSHIP: ______________	______________________________
EMAIL: ______________________________	CONSENT: ____________YES ___________NO

D. EMPLOYMENT HISTORY (Recent employment first)

1. EMPLOYER'S FULL NAME & ADDRESS	FROM: (month/year) _______/_______ TO: (month/year) _______/_______	JOB TITLE
DEPT / AREA WORKED: (eg. OPD, ER, OB etc.)	REASON FOR LEAVING:	
BRIEF DISCRIPTION OF DUTIES (Please ensure to include level of responsibility, number of hospital beds, nurse/patient ratio, type of equipment used, and dept / area worked):		

2. EMPLOYER'S FULL NAME & ADDRESS	FROM: (month/year) _______/_______ TO: (month/year) _______/_______	JOB TITLE
DEPT / AREA WORKED: (eg. OPD, ER, OB etc.)	REASON FOR LEAVING:	
BRIEF DISCRIPTION OF DUTIES (Please ensure to include level of responsibility, number of hospital beds, nurse/patient ratio, type of equipment used, and dept / area worked):		

3. EMPLOYER'S FULL NAME & ADDRESS	FROM: (month/year) _______/_______ TO: (month/year) _______/_______	JOB TITLE
DEPT / AREA WORKED: (eg. OPD, ER, OB etc.)	REASON FOR LEAVING:	
BRIEF DISCRIPTION OF DUTIES (Please ensure to include level of responsibility, number of hospital beds, nurse/patient ratio, type of equipment used, and dept / area worked):		

<table>
<tr><td>4. EMPLOYER'S FULL NAME & ADDRESS</td><td>FROM: (month/year)

_______/_______
TO: (month/year)

_______/_______</td><td>JOB TITLE</td></tr>
<tr><td>DEPT / AREA WORKED:
(eg. OPD, ER, OB etc.)</td><td colspan="2">REASON FOR LEAVING:</td></tr>
<tr><td colspan="3">BRIEF DISCRIPTION OF DUTIES (Please ensure to include level of responsibility, number of hospital beds, nurse/patient ratio, type of equipment used, and dept / area worked):</td></tr>
</table>

E. MEDICAL HISTORY

NAME: ____ **DATE OF BIRTH:** ______________________________

HEIGHT: ______________________________________ **WEIGHT:** ____________________________________

BLOOD GROUP: ______________________________

The questionnaire below must be completed as fully as possible. **ALL** questions must be answered. The information will be treated in strictest confidence.

WARNING: In completing the questionnaire, you are responsible for the accuracy of your statements. If information is withheld, suppressed, deliberately misleading or false, you may be liable, if employed, to be dismissed.

		YES	NO			YES	NO
1	Do you presently suffer from any illness that requires:			7	Have you had a TB skin test?		
	Regular visits to doctor				If yes, when ________________________		
	Hospitalization				Results: Positive Negative		
	Regular treatments			8	Have you had the series of 3 vaccinations against Hepatitis B?		
	Therapeutic modalities						
2	Are you currently taking any medications?			9	Have you had an antibody titer to assess the Hepatitis B vaccine?		
3	Are you on a special diet?						
	If yes, please provide details.				Results: Positive Negative		
4	Do you have any allergies?			10	Have you had the series of 3 vaccinations against Hepatitis A?		
	If yes, please note them.						
5	Have you ever ended employment because of:			11	Is your sight good enough for all usual activities in the:		
	Being terminated due to ill health?				Right eye?		
	Having to resign due to ill health?				Left eye?		
	Being made redundant due to ill health?			12	Do you wear eye glasses?		
6	Have you had any of the following conditions?			13	Do you wear contact lenses?		
	Hepatitis			14	If you use corrective glasses/contact lenses, are you able to see well enough to do the usual activities?		
	Cancer						
	Angina				Right eye		
	Myocardial Infarction				Left eye		
	Hypertension			15	Is your hearing good enough for normal activities in the:		
	Bronchitis				Right ear		
	Asthma				Left ear		
	Pneumonia			16	Do you wear a hearing aid?		
	Tuberculosis			17	Do you suffer from frequent insomnia or other sleep disorders?		
	Psychiatric Problems						
	Neurological Disorders			18	Do you smoke?		
	Headache, reoccurring				If yes, how many per day?		
	Migraine			19	What was the date o your last medical examination?		
	Ulcers						
	Rectal Bleeding			20	What was the date of your last chest X-ray?		
	Diverticulitis						
	Dyspepsia			21	How many sick days have you had in the 3 three years?		
	Diabetes						
	Thyroid Problems			22	Have you had a serious injury from an accident in the last 2 years?		
	Dysmenoorrhea, reoccurring (Females only)						
	Endometriosis			23	Do you have any symptoms that prevent you from going to work?		
	Urinary Tract Infection, reoccurring						

	YES	NO			YES	NO
Kidney Stones			24	Do you have, or have you had any defect, disorder or other condition, mental or physical not already mentioned in any of your answers?		
Pylonephritis						
Renal Failure						
Back Trouble						
Neck Problems			25	Have you been discharged from Military Service because of ill health?		
Sciatica						
Varicose Veins			26	Are you or have ever been registered as "Disabled"?		
Haemorrhoids						
Dermatitis			27	Are you in receipt of a war pension or any other disability benefit?		
Psoriasis						
Prostate Problems (Males only)			28	Have you ever been hospitalized?		
SIGNATURE			**DATE**			

IF YOU ANSWERED **YES** TO ANY OF THESE QUESTIONS, PLEASE **EXPLAIN** BELOW. YOU MAY ATTACH EXTRA SHEETS AS REQUIRED.

NUMBER	CONDITION	EXPLANATION

F. SIGNATURES:

I hereby declare that the seven (7) pages written particulars are true and accurate to the best of my knowledge. I understand that false statement may disqualify my employment or may result in dismissal.

SIGNATURE OF APPLICANT: ______________________________ **DATE:** __________________________

THANK YOU FOR YOUR TIME TO COMPLETE THIS APPLICATION FORM.
PLEASE NOTE THAT APPLICATIONS EXPIRE AFTER SIX MONTHS

PRIMARY SOURCE VERIFICATION

As an essential function and responsibility of a Recruitment Agency, I confirm that Primary Source Verifications of the above applicant's license, qualification and experience will be implemented when offer released.

SIGNATURE OF RECRUITMENT AGENCY: ______________________________ **DATE:** ____________________
(AGENCY STAMP)

E. MEDICAL HISTORY

NAME: ____ **DATE OF BIRTH:** ______________________________

HEIGHT: ______________________________________ **WEIGHT:** ____________________________________

BLOOD GROUP: ______________________________

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