King Salman Armed Forces Hospital- Northwestern Region
P.O. Box 100, Tabuk City, Kingdom of Saudi Arabia
www.nwafh.med.sa

Recruitment Services Section
E-mail: recruitment@nwafh.med.sa
Tel.nos.: 00966-14-441-85191/85197
Fax no.:00966-14-441-1060

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: _____ **JOB TITLE:** _____ **PROFESSIONAL RELATIONSHIP:** _____ **EMAIL:** _____	**ADDRESSES INCLUDE PHONE & FAX CONTACT NO.** _____ _____ **CONSENT:** _____**YES** _____**NO**
4. NAME: _____ **JOB TITLE:** _____ **PROFESSIONAL RELATIONSHIP:** _____ **EMAIL:** _____	**ADDRESSES INCLUDE PHONE & FAX CONTACT NO.** _____ _____ **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):		

4. 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):		

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
1	Do you presently suffer from any illness that requires:		
	Regular visits to doctor		
	Hospitalization		
	Regular treatments		
	Therapeutic modalities		
2	Are you currently taking any medications?		
3	Are you on a special diet?		
	If yes, please provide details.		
4	Do you have any allergies?		
	If yes, please note them.		
5	Have you ever ended employment because of:		
	Being terminated due to ill health?		
	Having to resign due to ill health?		
	Being made redundant due to ill health?		
6	Have you had any of the following conditions?		
	Hepatitis		
	Cancer		
	Angina		
	Myocardial Infarction		
	Hypertension		
	Bronchitis		
	Asthma		
	Pneumonia		
	Tuberculosis		
	Psychiatric Problems		
	Neurological Disorders		
	Headache, reoccurring		
	Migraine		
	Ulcers		
	Rectal Bleeding		
	Diverticulitis		
	Dyspepsia		
	Diabetes		
	Thyroid Problems		
	Dysmenoorrhea, reoccurring (Females only)		
	Endometriosis		
	Urinary Tract Infection, reoccurring		

		YES	NO
7	Have you had a TB skin test?		
	If yes, when _____ Results: Positive Negative		
8	Have you had the series of 3 vaccinations against Hepatitis B?		
9	Have you had an antibody titer to assess the Hepatitis B vaccine?		
	Results: Positive Negative		
10	Have you had the series of 3 vaccinations against Hepatitis A?		
11	Is your sight good enough for all usual activities in the:		
	Right eye?		
	Left eye?		
12	Do you wear eye glasses?		
13	Do you wear contact lenses?		
14	If you use corrective glasses/contact lenses, are you able to see well enough to do the usual activities?		
	Right eye		
	Left eye		
15	Is your hearing good enough for normal activities in the:		
	Right ear		
	Left ear		
16	Do you wear a hearing aid?		
17	Do you suffer from frequent insomnia or other sleep disorders?		
18	Do you smoke?		
	If yes, how many per day?		
19	What was the date o your last medical examination?		
20	What was the date of your last chest X-ray?		
21	How many sick days have you had in the 3 three years?		
22	Have you had a serious injury from an accident in the last 2 years?		
23	Do you have any symptoms that prevent you from going to work?		

		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 VERIFICAITON

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:** _____

(STAMP)

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 VERIFICAITON

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:** _____

(STAMP)