دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

APPLICATION FOR APPROVED PRACTICE SETTING (APS)

SEPTEMBER 2025

SECTION A: FACILITY INFROMATION

1. **Facility Name:**
2. **Facility License Number:**
3. **Address:**

   Region: Abu Dhabi
4. **Authorized Facility Academic Officer/Designated Institutional Official (DIO):**

   Name: Title:

   License number:

   Email: Phone:
5. **Coordinator:**

   Name:

   Email: Phone:

SECTION B: APPLICATION DETAILS

1. **Type of Application**

   ☐ New APS

   ☐ APS Renewal
2. **Approved Practice Setting Category Requested**

   ☐ **APS – B (Basic)**

   ☐ Observership. Category: Medical Students

   Specify Specialty:

   ☐ Undergraduate Training. Category: Medicine

   Specify Specialty:

   ☐ **APS-I (Intermediate)**

   ☐ Medical Internship

   ☐ Dental Internship

   ☐ Return-to-Practice. Category: Allied Healthcare Professionals

   Specify Specialty:

   ☐ Clinical Training. Category: Nursing and Midwives

   Specify Specialty:

☐ **APS-A (Advanced)**

- ☐ Residency, specify Specialty
- ☐ Fellowship/Subspecialty, specify Subspecialty
- ☐ Certification Program, specify Program

SECTION C: PROGRAM DETAILS

Complete program details for each program offered.

1. **Program Name:**
2. **Accreditation/Academic Affiliation** (attach accreditation letter and/or academic affiliation MOU)
3. **Proposed number of trainees per year:**
4. **Training Overview -** Provide a brief overview of the training program and expected learning outcomes (max 250 words).

5. **Program Director**

   Name: Title:

   License number:

   Email: Phone:

6. **Faculty Details -** Attach Faculty List, Qualifications, License numbers

   Number of Faculty:

   Faculty to Trainee ratio:

SECTION D: COMPLIANCE AND DECLARATION

Upon submission of the complete application, DOH Medical Education will review all submitted documents. Additional information and a site visit may be required.

I declare that all information submitted is accurate and complete. I understand this is an application process and by no means grants the recognition or endorsement of the Department of Health.

I acknowledge that the training program cannot start or enroll trainees without prior approval of DOH.

Program Director

Name:

Signature:

Date:

Designated Institutional Official

Name:

Signature:

Date:

Hospital Leadership Endorsement (Medical Director/Chief Medical or Executive Officer)

Name:

Signature:

Date:

Please attach all required documents along with the complete application form.

Document	APS-B: Observership	APS-B: Undergraduate	APS-I: Return to Practice	APS-I: Clinical Training	Internship + APS-A	Renewal
Executive Leadership Endorsement Letter	✓	✓	✓	✓	✓	✓
Institutional Accreditation Letter					✓	✓*
Program Accreditation Letter					✓	✓*
Academic Institution MOU		✓				✓*
Academic Governance Structure/Organizational Chart	✓	✓	✓	✓	✓	✓
Faculty List, Qualifications and Licenses	✓	✓	✓	✓	✓	✓
Academic and Training Policies including confidentiality, patient consent, academic integrity and conduct, and malpractice and professional liability insurance policy.	✓	✓	✓	✓	✓	✓
Training Supervision Policy	✓	✓	✓	✓	✓	✓
Training Objectives	✓	✓	✓	✓		
Attendance and Wellbeing Policy	✓	✓	✓	✓		
Assessment and Feedback policy	✓	✓	✓	✓		
Number of enrolled trainees per category since last APS renewal						✓

***only if required during initial application**