دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

APPLICATION FOR APPROVED PRACTICE SETTING (APS)

SEPTEMBER 2026

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
☐ Dental Students
☐ Nursing and Midwifery Students
☐ Allied Healthcare Students
☐ Traditional and Complementary Medicine Students

☐ Undergraduate Training. Category:

☐ Medicine
☐ Dentistry
☐ Nursing and Midwifery
☐ Allied Healthcare
☐ Traditional Complementary and Integradtive Medicine

☐ **APS-I (Intermediate)**

☐ Medical Internship ☐ Dental Internship

☐ Return-to-Practice. Category:

☐ Physicians
☐ Dentists
☐ Nurses and Midwives
☐ Allied Healthcare Professionals
☐ Traditional Complementary and Integrative Medicine Practitioners

☐ Clinical Training. Category:

☐ Nursing and Midwives
☐ Allied Healthcare Professionals
☐ Traditional Complementary and Integrative Medicine Practitioners

☐ **APS-A (Advanced)**
- ☐ Residency
- ☐ 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. **Faculty Details -** Attach Faculty List, Qualifications, License numbers
   Number of Faculty:
   Faculty to Trainee ratio:
6. **Program Director**

Name: Title:

License number:

Email: Phone:

Signature:

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.

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	✓	✓	✓	✓	✓	✓
Funding schemes/Plan	✓	✓	✓	✓	✓	✓
Patient Volume in the Last 12 Months	✓	✓	✓	✓	✓	✓
Academic and Training Policies include 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						✓

*** APS – B and APS – I require quality institute certificate example (ISO, JCIA). APS – A requires NIHS institute certificate.**
**** Only if required during initial application.**