دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

APPLICATION FOR REGULATORY ENDORSEMENT OF HEALTH PROFESSIONAL TRAINING PROGRAMS

Sep 2021

Workforce Licensing and Medical Education Division

INTRODUCTION

The Department of Health (DOH), in its capacity as the primary regulatory authority for the healthcare sector in Abu Dhabi endorses, sets standards, and audits medical education programs for all Abu Dhabi health professionals. The DOH also licenses all health professionals (including trainees and graduates of programs) and health training facilities.

To ensure the advancement of health professionals who participate in training, all health professional training programs must be recognized by the Department of Health and must be conducted within its accredited training facilities.

As of Jul 2021, this application is to be used for all new academic programs in Abu Dhabi who wish to receive official recognition/endorsement from the post graduate education section at the Department of Health.

We highly recommend that this form be completed by senior academic leadership at the training institution as it requires detailed information on the academic content and structure of the program.

We commend you on your interest in providing post graduate training and look forward to working with you to ensure the highest standard of clinical education.

1. APPLICATION INFORMATION	
1.1. Type of Program (tick all that applies): O Intermediate: Internship O Intermediate: Return Back to Practice O Intermediate: Experience Equivalency O Advance: Residency O Advance: Fellowship	
1.2. Program Name:	
1.3. Program Duration:	
1.4. Facility Name:	
1.5. Facility License:	
1.6. Program Director Name:	
1.7. Program Director License No.:	
1.8. Program Director Phone No.:	
1.9. Program Director Email:	
1.10. **Attachment1:** Please attach the CVs of Program Director mentioned above.	
1.11. Justification and Main Goals of the Program: _____ _____ _____ _____ _____	

1.12. Are there other training facilities participating in this program?
O Yes, Name: _____ License Number: _____
O No

1.13. Please add a description of contributions of each participating facility to the program (including time spent/specific rotations spent in each of the participating institutions) and the corresponding academic dept/GMEC letter of approval/partnership.

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1.14. Please provide details on the key faculty of the program.

Name:	License No.:
Name:	License No.:
Name:	License No.:
Name:	License No.:
Name:	License No.:
Name:	License No.:
Name:	License No.:

1.15. **Attachment 2:** Please attach the CVs of training faculty mentioned above.

1.16. **Attachment 3:** Please upload job descriptions for the Program Director and Faculty with clear provisions on protected time offered.

2. ELIGIBILITY CRITERIA/SELECTION PROCESS FOR TRAINEES
2.1. Please describe the qualifications/eligibility criteria required for candidates who wish to attend this program. _____ _____ _____ _____ _____
2.2. Please provide a detailed description of trainee selection process to be used by your program. _____ _____ _____ _____ _____
2.3. Intended number of trainees to be accepted PER YEAR. _____
2.4. Please indicate when you plan on enrolling the first class of trainees. MM_____YYYY_____
3. PROGRAM DETAILS
3.1. **Attachment 4:** Please attach an abbreviated curriculum with aims and objectives of each rotation
3.2. Please indicate the accrediting body for this program.
3.3. Please provide details on how the program will ensure that the trainee experiences graded responsibility for each completed academic term/year. _____ _____ _____ _____

4. EVALUATION
4.1. Please provide a description of evaluation methods used to evaluate trainees: _____ _____ _____ _____ _____
4.2. Please provide a description of evaluation methods used to evaluate core faculty involved in teaching activities: _____ _____ _____ _____ _____
4.3. Please provide a description of evaluation methods used to evaluate academic activities of the program. _____ _____ _____ _____ _____
4.4. Please provide a detailed description of mandatory requirements/achievements for trainee advancement from year to year. (e.g. successful passing of in-training exam) _____ _____ _____ _____ _____

4.5. Is there a final/exit examination for graduates of the program?
O Yes, Name:
O No

4.6. Please describe how completion of your program will contribute to the qualifications/ licensure status of graduated trainees.

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5. SUBMISSION OF REQUEST

Upon submission of your application, DOH ME officials will review your application and get back to you within 10 business days using the contact information provided in your application.

PLEASE NOTE, YOU WILL NOT BE ABLE TO ALTER THIS APPLICATION IN ANY WAY ONCE SUBMITTED. PLEASE REVIEW YOUR APPLICATION THOROUGHLY PRIOR TO SUBMITTING

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

Date:_____

O I agree

Program Director Name:

_____
Program Director Signature:

O I agree

Designated Institute Official Name:

_____
Designated Institute Official Name: