KHYBER MEDICAL UNIVERSITY
PHASE-V, HAYATABAD, PESHAWAR
KHYBER PAKHTUNKHWA, PAKISTAN
Phone: 091-9217703, Fax: 091-9217704

PMC Registration Number

Please paste one Photograph and then get is attested by the person specified overleaf as in instruction 4

The Registrar
Khyber Medical University
Phase-V, Hayatabad, Peshawar

Subject: **RECOGNITION OF EXPERIENCE**

Dear Sir,

I am enclosing experience certificates (instructions overleaf) as per details given below for recognition. Please issue me experience certificate for ____________________ purpose). My PMC Registration No. is ____

Sr. No.	Detail of experience		Department & Institution
	Designation	Duration (dates)	

Sr. No.	Details of original articles (attached original Journals)	Published in

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Undertaking:

I undertake to abide by the Code of Ethics prescribed by the KMU for registered Medical / Dental practitioner and will inform the Registrar, Khyber Medical University, Peshawar of any change of address of residence or practice with in their days. If considered necessary, KMU may disclose any information when asked for or obtain any information from any of my institution of which teach / practical experience is being claimed and I liberate KMU for any liability for this action. I further undertake that if there has been an erroneous entry in the certificate and I am told by the KMU to send the certificate back to KMU, I shall do so immediately and shall not take any benefit of the error. Above information is correct and nothing has been concealed. I take full responsibility of authenticity of documents submitted along with this application.

SUBJECT TO INSTRUCTIONS OVERLEAF

Address ______________________________

____

Tel: ____________ Email: ________________

*Attach extra sheet if required

Signature______________________

Name__________________________

Designation ____________________

Date___________________

General Information

a. The experience certificate is issued on the basis of experience as communicated by the Principal/Dean/head of teaching institutions, and is liable to be modified on the Dean/Principal's request.
b. The experience certificates enclosed with this form for recognition must contain the details of nature and job, period of job (day, month and year) in addition to name of doctor and must be submitted by.
c. In case of eligibility for teaching appointments or other Government Servants should route their applications through proper channel.
d. The applicant should be fully aware of the fact that the experience certificate is accepted / processed and issued in accordance with KMU rules.
e. Applicants with incomplete or deficient information shall not be processed.
f. Application forms not accompanied by publications as required by KMU shall not be processed.
g. Fee shall be remitted with every submission.
h. There shall be no urgent processing of the experience certificate.

Local Experience:
Teaching experience certificate must be issued by the Principal / Dean or Head of the Institution recognized by PMC on official letter-head mentioning his name clearly. **The testimonials issued by the teachers / medical superintendents are not acceptable.** The following document must accompany the form on pre-page:-

i. This form (per-page) duly filled-in and signed by the doctor.
ii. Three passport size photograph duly attested by the Medical Superintendent of a District Headquarters level hospital or Principal of a Medical / Dental College or by the member of the Councilor by authorized officer of Pakistan "Embassy aboard with white background and both ears are visible.
iii. Three Photostat copies each of the experience certificate duly attested separately by the person specified above.
iv. Photostat copy of the valid registration certificate.
v. Three Photostat copies of each experience certificate duly attested separately by the person specified above.
vi. Experience certificate fee of Rs. 1950/- through Bank Draft / Pay Order in favour of KMU Peshawar.
vii. Courier charges according to the no of institution, where the applicant has worked with be Rs. **200/- per** courier through Bank Draft / Pay Order in favour of KMU Peshawar.
viii. An Affidavit on Rs. 10/- Stamp Paper (specimen No. 1 & 2).
ix. Statement by Director Finance / Treasurer (Specimen no. 3)
x. Submitted certification order from Health Department.

Foreign Nationals and Pakistani doctors applying from foreign countries should pay equivalent amount in foreign exchange through Bank Draft / Cashier's Cheque of a recognized bank payable in Pakistan in favour of bank account titled "KMU Peshawar" (without mentioning account number). For further details to submit fee while being abroad kindly visit our website.

Foreign Experience:

a. This form (per-page) duly filled-in and signed by the doctor.
b. Photostat copy of valid registration certificate under which basic as well as postgraduate qualifications are registered with PMC.
c. Four Photostat copies of each experience certificate (signed by the Head of Institute) duly attested by the Principal of any Medical / Dental College in Pakistan who knows you personally OR by an authorized Officer of Pakistan Embassy in that Country OR by an authorized Officer of the Ministry of Foreign Affairs in Pakistan OR by member of the Council who know you personally.
d. Three passport size photographs duly attested by the person specified above.
e. Complete Bio-Data duly signed.
f. Experience certificate fee of Rs. 1950/- through Bank Draft/Pay order in Favour of KMU Peshawar.
g. Processing fee Rs. 6500/- (non-refundable) through Bank Draft/Pay Order in favour of KMU Peshawar.
h. Green Proforma A for recognition of foreign experience (Annex-l).
i. Please fill out the release liability form.

Additional Copy of Experience Certificate:

a. An application on plain paper referring previous experience certificate etc. mentioning PMC registration number, and purpose of additional copy.
b. Two passport size photographs duly attested by the person specified above.
c. Experience Certificate fee of Rs. 650/- through Bank Draft/Pay Order in favour of KMU Peshawar.
d. An affidavit of Rs. 10/- Judicial Stamp Paper (specimen No. 4).

Publications/Articles:

Provide original Journals in which articles were published and copies of each article and front page of the Journal, duly attested by a professor of a recognized medical / dental college.

SPECIMEN NO. 1 OF AFFIDAVIT ON STAMP PAPER OF RS. 10/-

For Issuance of Experience Certificate

AFFIDAVIT

(DEMONSTRATOR / LECTURER / SENIOR DEMONSTRATOR / SENIOR LECTURER / SENIOR REGISTRAR / ASSISTANT PROFESSOR / ASSOCIATE PROFESSOR & PROFESSOR ETC.................. MEDICAL / DENTAL COLLEGE / UNIVERSITY / DAIS)

Affidavit of Mr. Mrs. Dr.________________________________S/o, D/o_____________________________ CNIC No.______________________________PMC No. ________________________________ Designation__________________________(Demonstrator / Lecturer / Senior Demonstrator / Senior Lecturer / Senior Registrar / Assistant Professor / Associate Professor & Professor etc). Date of appointment_ __________________Department of Work_______________________________________Duration of appointment (from DD-MM-YY to DD-MM-YY) Personal responsibilities _____________________________(Visiting / Full time / Regular / Adhoc Basis etc), the undersigned duly affirm and declare the oath as under:-

1. That, I the undersigned duly depose that all the credentials, training letters, financial slips, present in my personal file are correct and true.

2. That the undersigned has not worked during his duty hours at any other department / institutions.

3. That I the undersigned shall be responsible personally and shall be liable to face any legal proceedings initiated before KMU in case any discrepancy is found in documents, any fake documents was submitted or any concealment of facts.

4. I am fully aware that more than one agency is involved in verification process and considerable time is consumed and I shall not pressurize or demand for any hurry. Will totally accept the decision of KMU shall not challenge it in any form. I am fully aware that submitting this application is in my own interest and shall wait till KMU responds patiently.

Note: Full Time Faculty i.e the faculty which is available in medical / dental college / university / hospital for teaching, training and education for at least six hours per day during college hours.

Deponent: __________________

Verification:-

It is verified, on oath dated____at________________that the above statement is correct and true to the best of my knowledge and belief and nothing has been concealed therein.

Deponent: __________________

SPECIMEN NO. 2 OF AFFIDAVIT ON STAMP PAPER OF RS. 10/-

For Issuance of Experience Certificate

AFFIDAVIT

(VICE CHANCELLOR / PRINCIPAL / DEAN / HEAD OF INSTITUTION
....MEDICAL / DENTAL COLLEGE / UNIVERSITY / DAI)

Affidavit of Mr. / Mrs. / Dr.____________________________________S/o / D/o______________________
CNIC No.____________________________________PMC No.____________________________________
R/O ____that the
Undersigned duly affirm and declare on oath as under.

1. That, I the undersigned is performing my duty as Vice Chancellor / Principal / Dean / Head of Institution at______________________________Medical / Dental College / University / DAI.

Authentication of Faculty

2. That, I the undersigned duly certify that all the credentials, training letters, financial slips of Mr. / Mrs. Dr. ______________________S/o, D/o__________________________ CNIC No.________________________ PMC No.__________ Designation________________________(Demonstrator / Lecturer / Senior Demonstrator / Senior Lecturer / Senior Registrar / Assistant Professor / Associate Professor & Professor etc). Date of appointment________________Department of Work___________________Duration of appointment (from DD-MM-YY to DD-MM-YY) Personal Responsibilities____________________________________(Visiting / Full time / Regular / Adhoc Basis), posted in this medical / dental college / university / DAI are correct and true.

3. That the above stated faculty will not work during his duty hour at any other department / institutions.

4. That I the undersigned shall be responsible personally and shall be liable to face any legal proceedings initiated before KMU in case any discrepancy is found in documents, any fake documents has submitted or any concealment of facts.

Note: Full Time Faculty i.e the faculty which is available in Medical / Dental College / University / Institution / Hospital for teaching, training and education for at least six hours per day during college hours.

Deponent: ___________________

Verification:-

It is verified, on oath dated____at that the above statement is correct and true to the best of my knowledge and belief and nothing has been concealed therein.

Deponent: ___________________

SPECIMEN NO. 3

For Issuance of Experience Certificate

STATEMENT

BY

(DIRECTOR FINANCE / TREASURER

...............MEDICAL / DENTAL COLLEGE / UNIVERSITY / DAI)

Statement of Mr. / Mrs.____________________________________S/o / D/o___________________________CNIC No.____________________________R/O____that the undersigned duly affirm and declare on oath as under.

1. That, I the undersigned is performing my duty as Director Finance / Treasurer at ______________________Medical / Dental College / University / DAIs.

Authentication of Pay Slips

2. That, I the undersigned duly certify that all the financial slips i.e Salary Slips and Tax Deposit certificate at FBR of Dr.____ S/o, D/o____CNIC No._____________________________PMC No. __________________ Designation_____________________________(Demonstrator / Lecturer / Senior Demonstrator / Senior Lecturer / Senior Registrar / Assistant Professor / Associate Professor & Professor etc) his date of appointment____Department of Work ___________________________Duration of appointment (from DD-MM-YY to DD-MM-YY) (Visiting / Full time / Regular / Adhoc Basis), posted in this medical / dental institution are correct and true.

4. That I the undersigned shall be responsible personally and shall be liable to face any legal proceedings initiated before PMC in case of any discrepancy is found in documents, any fake documents has submitted or any concealment of facts.

Name

(Director Finance / Treasurer)

SPECIMEN NO. 4 OF AFFIDAVIT ON STAMP PAPER OF RS. 10/-

For Issuance of Additional Copy of Recognized Experience certificate

I, Dr. ____________________________S/O, D/O_________________Regn No. _______________

Resident of ____do hereby solemnly affirm as under:-

1. A copy of experience certificate No. _____________________was issued to me which has been submitted to ____/mis-placed by me.
2. I require another copy of certificate for the purpose ______________________________.
3. I am not concealing the facts and will not misuse the experience certificate.
4. The above facts are true to the best of my knowledge.

Signature and Seal of the Court   Deponent

CONSENT TO RELEASE OF INFORMATION AND RELEASE OF LIABILITY IN RESPECT OF KMU Peshawar AND THE INSTITUTION (Foreign Teaching and Practical Experience)

1. Name of Authorizing Physician and Email Address: ______________________________
2. Identity of Institution/hospital or Person from whom information: is sought ______________________
3. **Said Experience Details** Designation______________________Specialty:______________
Subspecialty:______________Duration__________________Hospital / Institute ________
4. ***Requester*** Identity of Institution or Person requesting information: "KMU Peshawar
5. ***Provider (Hospital/Institute where experience was gained*** *with* its relevant hierarchy, staff and Faculty who 1 am authorizing to release information concerning me and my experience.

PURPOSE: I am providing this request and consent in order to facilitate the process and verification of my experience from the above institution (provider) by the KMU the requester.

REQUEST: 1 specifically request that (provider)________provide to the requester **or any** representative designated in writing by the requester, any and all information, documents, and records concerning" my professional performance; competence, character during attainment of experience including work experience and behavior while a resident and/or fellow, specifically including the circumstances of my departure from the institution. I further specifically request that (provider)_____provide such information whether it came into possession of that information prior to my residency/fellowship, during my residency/fellowship, or after my residency/fellowship towards attainment of the said experience.

CONSENT AND A AUTHORIZE: **I** hereby authorize the requester identified above, or any representative designated in writing by that requester, to consult with(provider)________its relevant hierarchy, staff and Faculty, in order to obtain any and all information, documents, and records concerning" my professional performance; competence, character, experience, work/teaching experience and behavior while a resident and/or fellow, specifically including the circumstances of my departure from the institution. I hereby consent to the release of any and all information, records, documents, and/or opinions that KMU may require in their sole discretion and this may be provided to the KMU (requestor) pursuant to this authorization. I further consent to the copying of documents by (provider) ____________its relevant hierarchy, staff and Faculty, and transmittal to the requester or its representatives, of any and all records, documents, and/or opinions described in the paragraphs above, as well as any other information, documents and/or opinions that may be material to an evaluation of my professional experience in order for KMU to consider it for registration and my competence to practice medicine, my experience to obtain or hold clinical privileges or professional credentials, and my moral and ethical experience for employment. I hereby consent to the consultation and to the provision of information, records, documents, and/or opinions described above to the requester now, or at any time in the future, in the event of a subsequent inquiry or request. I further consent to a supplemental consultation and to the provision of supplemental information, records, documents, and/or opinions at any time in the future in the event that the (requestor) KMU Peshawar its relevant hierarchy, staff and Faculty, in their sole discretion, determines for any reason that information or opinions it has previously provided pursuant to this release are no longer complete, accurate, or timely, or that such information should be amended to make it more complete, accurate, or timely.

WAIVER OF LIABILITY. I hereby release the requester, KMU Peshawar its relevant hierarchy, staff and Faculty, and their respective representatives from all liability, to the fullest extent permitted by the law, for any and all acts performed under this authorization, specifically including the provision of information, documents, or records pursuant to this request.

RELEASE AND WAIVER OF ALL CLAIMS: 1 specifically waive any claim for damages of any kind against (provider) _______its relevant 1 hierarchy, staff and Faculty, for acts performed pursuant to this authorization, to the fullest extent permitted by the law, including but not limited to claims of interference with contract, invasion of privacy, defamation, slander, discrimination, denial of employment, admission, licensure, or credentials, or negligence of any kind in the communication of such information to the requester or its representatives.

HOLD HARMLESS AND INDEMNIFICATION: I hereby agree to hold (Provider)____its relevant hierarchy, staff and Faculty, and their representatives harm less from any and all claims made against them by me, the requester, or any other person or entity as a result of the release of information, documents, or records pursuant to this authorization. Specifically included in "hold harmless and indemnification" within this paragraph are any claims arising from denial of employment, admission, or credentials to me-by the requester or its representatives. I further specifically agree to indemnify (Provider)________________its relevant hierarchy, staff and Faculty and their Representatives for any and all legal fees, costs, or any other expenses incurred in defending any claim arising from the release of information, records, or documents sought by this request or provided pursuant to this authorization.

I shall pay fee for this verification to the provider if any,

Signature of Authorizing Physician______________________Date____________________

Print Name of Authorizing Physician ______________________________________

CHECK LIST FOR APPLICANT

Dear Dr.

Please ensure		Yes	.No
1.	You have filled in the KMU Peshawar Form-IV for recognition of experience completely.		
2.	You have attached required copies of teaching experience certificate duly issued by the Principal / Dean / Vice Chancellor of the concerned teaching medical / dental institutions where you have served.		
3.	You have attached three latest passport size photographs.		
4.	You have attach copy of degree/transcript of MBBS/BDS or equivalent qualification		
5.	You have attached one attested copy of each original article (if applicable)		abl
6.	You have routed your application through your Principal / Dean / Vice Chancellor if you are in service applicant.		
7.	You have got your experience certificates issued by Medical Superintendent / in charge of the hospital countersigned by your Principal / Dean / Vice Chancellor.		
8.	You have attached the required Affidavits vide specimen No. 1 & 2 given on KMU Form.		
9.	You have attached duly filled Green Proforma A (For Recognition of Foreign Experience only).		
10.	You have attached the Statement by Director Finance / Treasurer vide specimen No. 3 given on KMU Form.		
11.	Consent to release of information and release of liability in respect of KMU and the Institution duly filled and signed by the candidate.		
12.	You have attached a copy of MS/M.Phil transcript/degree		
13.	You have attached a copy of PhD/FCPS transcript/degree		

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Name and Signature of Applicant

Dated: __________________________

Annexure-I

Government of Khyber Pakhtunkhwa
Khyber Medical University, Peshawar
Green-A Performa for obtaining additional information about foreign work experience
To be filled for EACH DESIGNATION held by the applicant doctor

To be filled in by the candidate

Name of the Doctor: ______________________________

Name & address of Hospital/workplace: ______________________________

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Field of Work / Specialty: ______________________________

Designation Held: ______________________________

Designation of first reporting officer: ______________________________

KINDLY MARK "X" IN THE RELEVANT BOX

1. Duration of work experience: In Date /Month/Year
   From : ☐☐☐☐☐☐☐
   To : ☐☐☐☐☐☐☐

2. Nature of the Appointment: ☐ Full time ☐ Part time ☐ Visiting

3. Prerequisite minimum academic qualification for the above stated Appointment/Designation: ______________________________

4. Prerequisite experience required for the above Stated Appointment/Designation: ______________________________

5. Whether the hospital is affiliated with any University/Medical School: ☐ Yes ☐ No

If yes please specify the name of University/Medical School: ______________________________

6. Please specify in percentage, the division of work between Clinical, teaching, research duties of the doctor: ☐ Teaching ☐ Clinical ☐ Research

7. If the doctor was involved in teaching, please specify The main category of students tutored ☐ Medical ☐ Nursing ☐ Para-medical

8. If the doctor was involved in teaching, please Please specify in percentage the teaching assignment ☐ Undergraduate ☐ Postgraduate

   a. If teaching undergraduate students , please specify Contact Hours - limited to

- Lectures/ Demonstrations/Tutorials:
* Minimum 50 minutes of continuous session Equals 1 contact hour ☐ Per week ☐ Per month

   b. If teaching post graduate students please specify Percentage of teaching work between Clinical teaching, research teaching of the doctor: ☐ Clinical ☐ Teaching

9. Please specify the reason for job termination/Resignation: ______________________________

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10. Any cases of malpractice / professional negligence during service : ☐ Yes ☐ No

14. Any other information which may be considered necessary ______________________________
to the recognition of work experience
(use additional Sheet if necessary). ______________________________

Signature of the Candidate:

PMC registration number: ______________________________

Email:______________________________

Contact No: ______________________

Address ___________________________