

A statement for the participated trainer in the postgraduate training programs

Training Program Name	
Training Center (Hospital)	
City	
English Name	
Arabic Name	
Specialty Type	
Specialty	
Training Start Date	
Training End Date	
Number of SCFHS ID	
Email	
Form Date	

Conditions:

- To have valid professional registration from the Saudi Commission for Health Specialties.
- To be a trainer participating in a training process for residents/fellows for an accredited program for SCFHS and provide a training activity for the trainees (at least one activity) in an accredited program.
- The trainer should have an evaluation as average or above by the program director and trainees.
- The application form should be signed by both the program director and the Designated Institutional Official (DIO) of the training center.
- The form of a trainer participating in the training process must be stamped with an official stamp from the Academic Affairs Administration at the training center.
- A statement will be issued after ensuring that all the information mentioned above matches the classification information.

Program Manager		DIO	
Name		Name	
Date		Date	
Signature		Signature	

