KUWAIT INSTITUTE FOR MEDICAL SPECIALIZATIONS

POSTGRADUATE EDUCATION OFFICE

REFERENCE LETTER REQUEST FORM

NAME : _____
(IN BLOCK LETTERS)

CIVIL IDENTIFICATION NUMBER:

MOH FILE NUMBER:

NAME OF PROGRAM:

_____

DATE OF JOINING THE PROGRAM:

_____

DATE OF COMPLETION (IF APPLICABLE):

_____

(Tick ☑ your current level.
R=Residency, F=Fellowship)

R1 ☐ R2 ☐ R3 ☐ R4 ☐ R5 ☐

Residency completed ☐

OR

F1 ☐ F2 ☐ F3 ☐

Fellowship completed ☐

DATE : _____
(of submission by **Candidate**)

SIGNATURE: _____
(Candidate)

DATE : _____
(of approval by **Program Director**)

SIGNATURE: _____
(Program Director)

Please submit the filled form to KIMS Postgraduate Education Office for processing.