

Send this form to
Socialstyrelsen
Behörighet
106 30 STOCKHOLM

Personal details

Last name, first name, middle name		Swedish personal identity no. or date of birth
Address		Phone
Postal code	City	Gender <input type="checkbox"/> Woman <input type="checkbox"/> Man <input type="checkbox"/> Other
Country		
E-mail address		

Profession

<input type="checkbox"/> Audiologist	<input type="checkbox"/> Doctor of Medicine	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Biomedical Scientist	<input type="checkbox"/> Healthcare Counselor	<input type="checkbox"/> Optician	<input type="checkbox"/> Psychotherapist
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Medical Physicist	<input type="checkbox"/> Orthopaedic Engineer	<input type="checkbox"/> Radiographer
<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> Midwife	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Speech Therapist
<input type="checkbox"/> Dental Practitioner	<input type="checkbox"/> Naprapath	<input type="checkbox"/> Physiotherapist	
<input type="checkbox"/> Dietitian	<input type="checkbox"/> Nurse responsible for general care	<input type="checkbox"/> Prescriptionist	

Education

Have you finished compulsory school education?	<input type="checkbox"/> Yes <input type="checkbox"/> No	From (year)	To (year)	No. of years	Country
Have you finished upper secondary education?	<input type="checkbox"/> Yes <input type="checkbox"/> No	From (year)	To (year)	No. of years	Country
Have you finished a post secondary education?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

<input type="checkbox"/> University/College	<input type="checkbox"/> Vocational School	<input type="checkbox"/> Other
Name of school, City		
Degree/Title		Year graduated
From (year)	To (year)	No. of years
Country		
Date on which you obtained a licence or approval to practice in the country where you were educated		

Have you obtained a licence or approval to practice in a country other than where you were educated?	<input type="checkbox"/> Yes Year	Country
	<input type="checkbox"/> No	

Have you worked in your profession after graduation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Employer	Profession	Period (yymmdd-yymmdd)

Please submit copies of these documents with your application

<input type="checkbox"/> A valid passport or a valid Swedish ID card
<input type="checkbox"/> A certificate of completed education, for example a diploma
<input type="checkbox"/> A certificate that lists the courses you took and how long the programme lasted
<input type="checkbox"/> A certificate that shows any changes you have made to your first or last name after completing the programme

Each document must be in both the original language and a Swedish or English translation. You must use an authorised translator. The translation can be made in any country.

Have you applied before?
<input type="checkbox"/> Yes <input type="checkbox"/> No

I agree that the Swedish National Board of Health and Welfare and the Swedish Council for Higher Education may contact my educational institution and the competent authority in the country where I was educated.
<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that the information I have provided on this form is correct

Date	Signature