APPLICATION FORM FOR REGISTRATION AS MEDICAL OR DENTAL PRACTITIONER

General data

Surname:.....

Names: .....

Date of Birth: ..... Sex:.....

Nationality: .....

Residential Address:..... Telephone No:.....

Emal Address:.....

Primary Medical or dental qualifications;

a) title (e.g MBBS, MB ChB, MD):.....
b) date on which qualification was conferred:.....
c) University or Body by which granted:.....
d) Medical or Dental College at which studied:.....
.....

Post-Graduate medical or dental qualifications

Title	Name of Institution	Country	Date

List in chronological order all the appointments in hospitals or in any other form of professional practice which you have undertaken since Primary Medical or dental Qualifications

Grade or Title of Post	Speciality	Dates when post began and ended	Name and address of hospital	Type of Hospital (Teaching General, etc.)

Please state whether or not you:

- have been convicted or found guilty by a court of law
- have been suspended or disqualified or prohibited from practising medicine or dentistry from being registered as a medical or dental practitioner, in any country:.....
- (State "Yes " or "No", if "Yes", please provide full details).....
- Type of registration applied for (24 months or up to 6 months):.....
- Address to which Documents are to be sent:.....

As confirmation that all of the information you have given above is accurate, please sign and date the application.

Signature:.....

Date:.....

If registration is granted, a Certificate will be despatched to you. You should not assume that registration has been granted, or take up practice on that assumption, until you have the Certificate.