Authorization to Release Information

This is to certify that I

Your Surname:

Your Name:

Your Date of Birth:

Your Nationality:

Your Passport Number:

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authorize the

(Name of Your Institution):

Address of Your Institution:

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to release all requested information about me to the **SEYCHELLES MEDICAL AND DENTAL COUNCIL** for the purposes of determining my suitability for registration as a Medical Practitioner or Dentist in the Republic of Seychelles

---------- (Signature)

---------- (Date)