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
18 9			
	5		
			7
			(4)

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	Speciality	Dates when	Name and address	Type of Hospital
Title of		post began	of hospital	(Teaching
Post		and ended	- Loopital	
		una chaca		General, etc.)
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Please state whether or not you:

18	have been convicted or found guilty by a court of law
*	have been suspended or disqualified or prohibited from practising medicine
	dentistry from being registered as a medical or dental practitioner, in any
	Country
23	(State "Yes" or "No", if "Yes", please provide full details)
文	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:	٠.	•	•	٠								
	10			2								
Date:						4			13			

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.