FORM A

THE MEDICAL ACT, 1976

APPLICATION FOR REGISTRATION AS A MEDICAL PRACTITIONER

To the Medical Council

Name of Applicant _____

Date of Applicant _____

Address of Applicant

_____

_____ Tel No. _____

Date of Birth of Applicant _____ Sex: M _____ F_____

Qualifications of Applicant _____

Where were Qualifications obtained?

_____

_____

_____

Signature of applicant

Note*

1. Full Registration – Original Degree Certificate
2. Certified Photostat or certified copies of academic certificates of diplomas;
3. Certificate of Registration or License;
4. Certificate of Good Standing with registering body or valid License;
5. Names and addresses of two (2) medical referees;
6. Passport size photograph.

TO BE COMPLETED BY THE REGISTRAR

Date of registration or refusal _____

Registration No. _____

Reason for refusal if refused _____

_____

_____

Signature of Registrar

N.B. Form may be copied, not typed over.
A PERSONAL INTERVIEW IS REQUIRED FOR FULL REGISTRATION.