

FORM A

THE MEDICAL ACT, 1976

APPLICATION FOR REGISTRATION AS A MEDICAL PRACTITIONER

To the Medical Council

Name of Applicant.....  
(Block letters)

Date of Application .....

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 Licence;
- 4) Certificate of Good Standing with registering body or valid Licence;
- 5) Names and addresses of two (2) medical referees;
- 6) Passport size photograph.

**TO BE COMPLETED BY TILE REGISTRAR**

Date of registration or refusal

Registration No.....

Reason for refusal if refused.....

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..... Signature of Registrar

N.B. form may be copied not typed over.

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A PERSONAL INTERVIEW IS REQUIRED FOR FULL REGISTRATION