

Place Passport picture using paper clip. Write your name at the back of picture

## MEDICAL AND DENTAL COUNCIL OF GHANA APPLICATION FOR TEMPORARY REGISTRATION

1.	Name in full:					
		Surname	First Name	Other N	lames	
	Dravious Nama(s):					
	Previous Name(s):	Surname	First Name	Other N	Other Names	
	Male Female Birth Date:/		Mrs. Miss	Prof Nationality:	Rev.	
	Working Address:		y Country			
	Working / Iddiess.					
			City/Town	Region		
	(		( )	( )		
		Tel. Ext.	Fax	Mobile	E-Mail	
	2. Home/Permanent: Address (If different from above):					
	from above).		City/Town	Region/C	ountry	
			( )	(		
		Tel. Ext.	() Fax	() Mobile	E-Mail	
	subsequently amended If yes, on what date? If no, which Licensing	onally registered under the Yes  / / / Authority were you register / / / / / / / / / / / / / / / / / / /	No What is your Regist ered with?	ration Number?		
	4. School(s)/College(	(s) University Attended	l			
	i. School	ol/College	from Day	/ / / to D	pay / / Y	
	ii. Schoo	ol/College	from Day	/ / / to D	pay / M Y	
	5. Qualification(s) fo	r Registration				
	i Degre	ee/Diploma		ate granted (	Granting Institution	
	ii				Granting Institution	
	Degre	e/Diploma	D	ate granted G	nanting institution	

## MDCG FORM 4

	<u> </u>	tration House Officer		Dates		N
	Hospital	Specialty	y Start	E	nd	Duration
Other Experience:				Dates		
	Hospital	Specialty	Post/Rank	Start	End	Duration
-						
						<u> </u>
Have If Ye	e you ever been found guies, Provide details inclusi	ilty of any criminal of ve of date, court and	ffence? Yes offence:		No	
If Ye	es, Provide details inclusive you ever had any discip	ve of date, court and o	offence:			
Have or an	es, Provide details inclusi	ve of date, court and o	offence:			
Have or an	e you ever had any discip	ve of date, court and o	offence:			
Have or an	es, Provide details inclusive you ever had any disciply employer? Yes es, Provide details inclusivees:	linary action taken ag  No  ve of date, court and	ainst you by th	e Medica		
Have or an	es, Provide details inclusive you ever had any disciply employer? Yes es, Provide details inclusivees:	ve of date, court and o	ainst you by th	e Medica		
Have or an If Ye	e you ever had any discipate employer? Yes es, Provide details inclusiones. Provide details inclusionees:	linary action taken ag  No  ve of date, court and	ainst you by th	e Medica		
Have or an If Ye	e you ever had any disciply employer? Yes es, Provide details inclusions.  rees: Name: Address	linary action taken ag  No  ve of date, court and	ainst you by th	e Medica	al and De	ental Counc
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## **MDCG FORM 4**

13. Certificate Statement.

I declare that the information on this application, other forms and documents submitted to the Medical and Dental Council of Ghana is provided in good faith and is true, completed and accurate. I understand that any misrepresentation may be caused for refusal or revoking of registration.

Signed	Date
N.B. C	Check List (In pursuance of this application I enclose):
	Diploma(s) / Certificate(s) – Original or Certified Copy(ies).  1 Passport Photograph  2 Letters of Reference( Referees should be in practice for at least 8 years or of the status of Principal Medical Officer and be in Goodstanding with the Council).  Registration Fees (\$400)
	Letters of Experience  Certification of Good Standing or Current license to Practice (applicable to all applicants not provisionally registered with Council)  Letter from Regional Director of Health Services (RHDS) of the Region in which the Practitioner would be working Evidence of selection for employment
	EVIDENCE OF SELECTION FOR EMPLOYMENT/ENGAGEMENT (TO BE COMPLETED BY EMPLOYING AUTHORITY)
	CERTIFICATE OF SELECTION FOR EMPLOYMENT/ ENGAGEMENT
must s	thorized officer of Hospital authority or sponsoring institution by which the applicant is to be employed sign this certificate.
It is he	ereby certified that(Name of applicant)
(this is Hospit	som this application is made, has been selected for employment/engagement in a medical/dental capacity in the capacity of a practitioner of medicine, dentistry, surgery other - specify) in the under-mentioned tall or Institution (Full name and address, of the Hospital or Institution must be given and if more than one tall or Institution is involved, each must be specified).
	* * * * * * * * * * * * * * * * * * * *
Descri	iption of post of applicant
Period	d of employment/engagement
Name	Official position
Signat	tureDate:
37 D	All Journants in languages other than English should be translated to English

FOR OFFICE USE ONLY					
Received by	Date//				
Checked by					
Amount paid	Receipt No.				
Signature of Officer	Date/				
Registrar's Comments					
Signature					
Chairman's Approval					
Signature	///				
Approved: Yes □	No □ Date:/				
Registration Number					
Entered into database by					