

# MEDICAL AND DENTAL COUNCIL OF GHANA

## APPLICATION FOR TEMPORARY REGISTRATION

- |    |                |                |                      |
|----|----------------|----------------|----------------------|
| ii | _____          | ____/____/____ | _____                |
|    | Degree/Diploma | Date granted   | Granting Institution |

**MDCG FORM 4**

6 Category      Medical ☐      Dental ☐

7 Work Experience as Pre-registration House Officer/Intern:

Hospital	Specialty	Dates		Duration
		Start	End	

8 Other Experience:

Hospital	Specialty	Post/Rank	Dates		Duration
			Start	End	

9 Specialty if any: \_\_\_\_\_

10 Have you ever been found guilty of any criminal offence?    Yes ☐      No ☐

**If Yes**, Provide details inclusive of date, court and offence: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11 Have you ever had any disciplinary action taken against you by the Medical and Dental Council or any employer?    Yes ☐      No ☐

**If Yes**, Provide details inclusive of date, court and offence \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12 Referees:

i Name: \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_ Fax \_\_\_\_\_ E. mail \_\_\_\_\_

ii Name: \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_ Fax \_\_\_\_\_ E. mail \_\_\_\_\_

## 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. 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)
- ☐ C.V./Resume
- ☐ 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**

An authorized officer of Hospital authority or sponsoring institution by which the applicant is to be employed must sign this certificate.

It is hereby certified that.....  
(Name of applicant)

by whom this application is made, has been selected for employment/engagement in a medical/dental capacity (this is in the capacity of a practitioner of medicine, dentistry, surgery other - specify) in the under-mentioned Hospital or Institution (Full name and address, of the Hospital or Institution must be given and if more than one Hospital or Institution is involved, each must be specified).

.....  
.....  
.....

Description of post of applicant .....

Period of employment/engagement ..... from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Day M Y Day M Y

Name ..... Official position.....

Signature..... Date: .....

**N.B.** All documents in languages other than English should be translated to English.

**FOR OFFICE USE ONLY**

Received by ..... Date ...../...../.....

Checked by ..... Date ...../...../.....

Amount paid. .... Receipt No. ....

Signature of Officer ..... Date ...../...../.....

Registrar's Comments .....

Signature ..... Date ...../...../.....

Chairman's Approval .....

Signature ..... Date ...../...../.....

Approved:    Yes    ☐    No    ☐    Date: ...../...../.....

Registration Number .....

Entered into database by ..... Date: ...../...../.....