FORM A

THE MEDICAL ACT, 1976

APPLICATION FOR REGISTRATION AS A MEDICAL PRACTITIONER

Tel No	To the Medical Council				
Address of Applicant Tel No Date of Birth of Applicant Sex: M F Qualifications of Applicant Sex: M F 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	Name of Applicant				
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	2. Certified Photostat 3. Certificate of Regis 4. Certificate of Good 5. Names and addresse 6. Passport size photogous TO BE COMPLETED BY Date of registration or refuse Registration No	or certified copies of actration or License; Standing with registeries of two (2) medical regraph. THE REGISTRAR sal	eademic certifing body or veferees;	ificates of diplomas;	
Signature of Registrar				Signature of Regi	strar

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