



MEDICAL & DENTAL COUNCIL

Data & Information Unit

Please Attach 1
Passport-Size
Picture using paper
clip. Write your
name at the back of
the picture.
Thank You!!!

Practitioners Data Form-2011

Surname:

Other Names

Date of Birth..... Gender: [MALE] / [FEMALE]

Nationality..... Profession: Dental [] Medical []

Institution of Practice.....

Type of InstitutePublic [] Private [] Region

Working Address.....
.....
.....

Permanent/Home Address.....
.....
.....

Telephone Number.....

Mobile Number.....

E-Mail Address.....

Specialty or Area of Practice.....

Qualifications

Awarding Body

Year

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

Signature.....

Date.....