



# MEDICAL & DENTAL COUNCIL

Data Management Unit

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

## Practitioners Data Form-2008

Surname:.....

Other Names:.....

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

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

Working Address:.....

.....

.....

Permanent/Home Address:.....

.....

.....

Telephone Number:.....

Mobile Number:.....

E-Mail Address:.....

Institution of Practice:.....

Specialty or Area of Practice:.....

**Qualifications**

**Awarding Body**

**Year**

.....

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.....

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Signature:.....

Date:.....