

MDCG FORM 1



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

**MEDICAL AND DENTAL COUNCIL OF GHANA
APPLICATION FOR PROVISIONAL REGISTRATION**

1. Name in full: _____
Surname First Name Other Names

Previous Name(s): _____
Surname First Name Other Names

Male Female

Birth Date: _____ Birthplace: _____ Nationality: _____

2. Mailing Address _____

_____ City/Town Region

(_____) (_____) (_____) (_____)
Tel. Fax Mobile e-mail

Home/Permanent: _____
Address (If different from above):

_____ City/Town Region/Country

(_____) (_____) (_____) _____
Tel. Fax Mobile E-Mail

3. School(s)/College(s) University Attended

i. _____ from ____/____/____ to ____/____/____
Medical School Day M Y Day M Y

ii. _____ from ____/____/____ to ____/____/____
Medical School Day M Y Day M Y

iii. _____ from ____/____/____ to ____/____/____
Medical School Day M Y Day M Y

4. Qualification(s) for Registration

i. _____ / / _____
Degree/Diploma Date granted Granting Institution

ii. _____ / / _____
Degree/Diploma Date granted Granting Institution

iii. _____ / / _____
Degree/Diploma Date granted Granting Institution

5. Have you every been found guilty of any criminal offence? Yes No
If Yes, provide details inclusive of date, court and offence.....

.....

6. Referees: (*Referees should be in practice for at least 8 years and should be in Good Standing with the Council*).

i. Name.....

Address:.....

Tel. No:.....Fax.....E-Mail address:.....

ii Name.....

Address:.....

Tel. No.....Fax.....E-Mail.....

7. Certification 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, complete and accurate.

I understand that any misrepresentation may be cause for refusal or revoking of registration.

Signed.....

Date:.....

In pursuance of this application I enclose:

Diploma(s)Certificate(s) Certified Copy each (*Originals should be available for inspection*)

Passport Photograph

2 letters of Reference (*Referees should be in practice for at least 8 years and should be in Good Standing with the Council*).

Registration Fees

MDCG FORM I

FOR OFFICE USE ONLY

Received by

Date/...../.....
Day M Year

Checked by

Date/...../.....
Day M Year

Amount paid. Receipt No.

Signature of Officer

Date/...../.....
Day M Year

Registrar's Comments:

.....
.....

Signature

Date/...../.....
Day M Year

Chairman's Approval.

.....

Signature

Date/...../.....
Day M Year

Approved: Yes No

Date:/...../.....
Day M Year

Registration Number

Entered into database by

Date:/...../.....