



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

MEDICAL AND DENTAL COUNCIL OF GHANA APPLICATION FOR REGISTRATION OF ADDITIONAL QUALIFICATION

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

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

Male Female Mr. Miss Prof. Rev.

Birth Date: ____/____/____ Birthplace: _____ Nationality: _____
Day Month Year City Country

Marital Status: Single Married

Mailing/Contact Address _____
(For entry into Register)

City/Town Region

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

2. Home/Permanent Address (if different From above): _____

City/Town Region/Country

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

3. Professional qualification already registered _____ Licensing Body _____

4. Additional qualification with dates _____ Granting Institution _____

5. References: I submit references from 2 personal referees (not relations) to whom I am well known.

Signature of Applicant _____

Date _____

MDCG FORM 3

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 or of the status of Principal Medical Officer and should be in Good Standing with the Council*).
- Registration Fees

FOR OFFICE USE ONLY

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

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

Amount paid. Receipt No.

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

Registrar's Comments:

.....
.....

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

Credentials Committee's Comments.

.....
.....

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

Chairman's Approval.

.....
.....

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

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

Registration Number

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