

MDC FORM 4



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

**MEDICAL AND DENTAL COUNCIL OF GHANA**  
**APPLICATION FOR THE REGISTRATION EXAMINATION FOR**  
**FOREIGN DOCTORS**

1. Name in full: \_\_\_\_\_  
Surname First Name Other Names

Previous Name(s): \_\_\_\_\_  
Surname First Name Other Names

Male  Female  Title: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace: \_\_\_\_\_ Nationality: \_\_\_\_\_  
City Country

Working Address: \_\_\_\_\_  
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. Have you been provisionally registered under the Medical and Dental Council Decree NRCDC 91 (1972) as subsequently amended? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, on what date? \_\_\_\_/\_\_\_\_/\_\_\_\_ What is your Registration Number? \_\_\_\_\_  
If no, which Licensing Authority were you registered with? \_\_\_\_\_  
Date of Registration \_\_\_\_/\_\_\_\_/\_\_\_\_ Registration Number \_\_\_\_\_

4. School(s)/College(s) University Attended  
i. \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Med. School Day M Y Day M Y  
ii. \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Med. School Day M Y Day M Y

5. Qualification(s) for Registration  
i. \_\_\_\_\_ /\_\_\_\_/\_\_\_\_ \_\_\_\_\_  
Degree/Diploma Date granted Granting Institution  
ii. \_\_\_\_\_ /\_\_\_\_/\_\_\_\_ \_\_\_\_\_  
Degree/Diploma Date granted Granting Institution

6. Category Medical  Dental

7. Work Experience as House Officer/Intern:

Hospital	Specialty	Dates		Duration
		Start	End	

8 Other Experience:

Hospital	Specialty	Post/Rank	Dates		Duration
			Start	End	

9 Specialty: \_\_\_\_\_

10 Have you ever been found guilty of any criminal offence? Yes  No   
 If Yes, Provide details inclusive of date, court and offence: \_\_\_\_\_

11. Have you ever had any disciplinary action taken against you by the Medical and Dental Council or any employer? Yes  No   
 If Yes, Provide details inclusive of date, court and offence \_\_\_\_\_

12. Referees:  
 i Name: \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tel. No. \_\_\_\_\_ Fax \_\_\_\_\_ E. mail \_\_\_\_\_  
 ii Name: \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tel. No. \_\_\_\_\_ Fax \_\_\_\_\_ E. mail \_\_\_\_\_

13. Certificate 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, completed and accurate.  
 I understand that any misrepresentation may cause the refusal or revoking of my registration.

Signed ..... Date .....

**N.B. Check List** (In pursuance of this application I enclose):

- Diploma(s)/ Certificate(s) Original or Certified Copy(ies).
- Passport Photograph

*N.B. All documents in languages other than English should be translated to English.*

**FOR OFFICE USE ONLY**

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

Checked by: \_\_\_\_\_ Date: \_\_\_\_\_

Amount Paid: \_\_\_\_\_ Date \_\_\_\_\_

Receipt No.: \_\_\_\_\_

Registrars Comment:- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Approved. Yes  No  Index No.: \_\_\_\_\_