



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

MEDICAL AND DENTAL COUNCIL OF GHANA
APPLICATION FOR FULL REGISTRATION

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

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

Male Female Mr. Mrs. Miss Prof Rev. Dr.

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 NRC D 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 ___/___/___
School/College Day M Y Day M Y

ii. _____ from ___/___/___ to ___/___/___
School/College 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

MDCG FORM 2

6 Category Medical Dental

7 Work Experience as Pre-registration 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 _____

MDCG FORM 2

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 be caused for refusal or revoking of 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
- 2 Letters of Reference(Referees should be in practice for at least 8 years or of the status of Principal Medical Officer and be in Goodstanding with the Council).
- Registration Fees
- Letters of Experience
- Certification of Good Standing or Current license to Practice (applicable to all applicants not provisionally registered with Council)
- C.V./Resume
- Evidence of selection for employment

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. Receipt No.

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

Registrar’s Comments

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

Chairman’s Approval

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

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

Registration Number

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