

بِسْمِ اللّٰهِ الرَّحْمٰنِ الرَّحِیْمِ

QI-MC/F/12/0059-1



Maldives Medical and Dental Council
Ministry of Health, Male', Republic of Maldives
Application for Provisional Registration

- Notice: 1- Please use BLOCK letters in filling this application form
2- Items I to IV are to be completed by the applicant.
3- Your application will be processed within ONE week.
4- Originals and a copy of each certificate and ID card must be submitted along with this application. All originals will be returned after verification.

Serial No:

Receipt No:

I PERSONAL DETAILS

Name: Sex: F M

Date of Birth: ID Card No:

Nationality: Contact Tel No:

Permanent Address:

Current Address:
(If different from above)

E- Mail Address:

*please paste a
recent passport size
photograph
here*

II (A) ACADEMIC QUALIFICATIONS (Including Secondary and Higher Secondary Education)

GCE O'LEVEL / EQUIVALENT EXAMINATION RESULTS

GCE A'LEVEL / EQUIVALENT EXAMINATION RESULTS

Subject	Grade	Year	Subject	Grade	Year
English Language	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mathematics	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Biology	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chemistry	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Physics	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

OTHER QUALIFICATIONS

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(B) PROFESSIONAL QUALIFICATIONS (MBBS or Equivalent)

Qualification	Institute	City / Country	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



III INTERNSHIP DETAILS* (If Known)

1. Proposed Institution for carrying out internship
2. Country where you intend to carry out internship
3. Expected date for commencement of the internship
4. Expected date for completion of the internship
5. Duration of Internship

*Where internship details are not provided, institution approval from Maldives Medical and Dental Council to be taken prior to commencing internship.

IV DOCUMENTS TO BE SUBMITTED

1. MBBS or equivalent (copy and originals)
2. Academic Qualifications (copy and originals)
3. Transcript (copy and originals)
4. ID card (copy and originals)

Declaration by Applicant

I hereby declare that the information provided by me in this application is true to the best of my knowledge. I am also aware that the provisional registration if issued to me is to be used only for and during the internship and it does not provide me with privileges to practice medicine independently.

Signature:

Date : day/month/year

For Official Use

Provisional Registration Number at Maldives Medical and Dental Council:

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Registered as:

Date : day/month/year

Signature :

Designation :