MEDICAL & DENTAL COUNCIL

"GUIDING THE PROFESSION, PROTECTING THE PUBLIC"

APPLICATION FOR LICENTIATE EXAMINATION

PHYSICIAN ASSISTANTS

MDCG/PA FORM 2

Place Passport Size picture using paper clip. Write your ***FULL*** name at the back of the picture (***Refer to page 3 for details***)

1. Name in full: ____

   Surname ***First Name*** ***Other Names***

2. Previous Name(s):____

   Surname ***First Name*** ***Other Names***

3. Male ☐ Female ☐ Title:____

4. Birth Date: ____/_____/_____ Birthplace:_________________________ Nationality:___________________

   City ***Country***

5. Contact Address: ____

   ____

   City/Town ***Region***

   (____________________)_(_______________)_(_____________)________________________________

   Tel. ***Fax*** ***Mobile*** ***E-Mail***

6. Home/Permanent Address (*If different from above*):_____________________________________

   ____

   City/Town ***Region/Country***

   (____________________)_(_______________)_(_____________)________________________________

   Tel. ***Fax*** ***Mobile*** ***E-Mail***

7. Have you been registered with a Council/Board? Yes ☐ No☐ If yes, on what date?___/___/_____

   Day M Y

8. Which Licensing Authority were you registered with?______________________________________

_______________________________________ Registration Number:____________________

9. School(s)/College(s)/University Attended:

i. ________________________________ From _____/____/____ To ___/_____/______

School(s)/College(s)/University *Day M Y* *Day M Y*

ii. _________________________________ From _____/____/____ To____/_____/______

School(s)/College(s)/University *Day M Y* *Day M Y*

10. Qualification(s) for Registration:

i __________________________________ _____/____/____ _______________________

Degree/Diploma Date granted Granting Institution

ii. ____________________________________ _____/____/____ _____________________

Degree/Diploma Date granted Granting Institution

11. Category: Medical ☐ Dental ☐ Anaesthesia☐

12. Work Experience:

Hospital	**Specialty**	**Dates**		**Duration**
		Start	**End**	

13. Have you ever been found guilty of any criminal offence? Yes ☐ No ☐

If Yes, Provide details inclusive of date, court and offence:___________________________________

____

____

14. Have you ever had any disciplinary action taken against you by any employer? Yes ☐ No ☐

    If Yes, Provide details inclusive of date, court and offence:____

    ____

    ____

15. Referees:

    i. Name: ____

       Address:____

       Contact No.:______________________ Fax:___________________ Email:________________________

    ii. Name: ____

       Address:____

       Contact No.:______________________ Fax:___________________ Email:________________________

16. Examination Centre: Accra ☐ Tamale ☐

17. 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 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)/Degree – Original or Certified Copy(ies).*
- ❑ *Passport Photograph*
- ❑ *Registration Fee*
- ❑ *Examination Centre*
- ❑ *CV/Resume*
- ❑ *Certificate used in applying for medical school (e.g. WASSCE Results)*

Your photos must be:

- ❑ In color
- ❑ Taken within the last 6 months to reflect your current appearance
- ❑ Taken in front of a plain white or off-white background
- ❑ Taken in full-face view directly facing the camera
- ❑ With a neutral facial expression and both eyes open
- ❑ Taken in clothing (***official***) that you normally wear

Any picture that does not conform with the above would be rejected

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.:____

Registrar's Comments: ____

____

Approved: Yes☐ No ☐

Index No.___________________