MEDICAL & DENTAL COUNCIL

"GUIDING THE PROFESSION, PROTECTING THE PUBLIC"

MDCG/PA FORM 2

APPLICATION FOR LICENTIATE EXAMINATION

PHYSICIAN ASSISTANTS

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*

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._____