MDCG FORM 4

Place Passport picture using paper clip. Write your name at the back of picture. Photo must be taken in official clothing.

MEDICAL AND DENTAL COUNCIL OF GHANA

APPLICATION FOR THE REGISTRATION EXAMINATION FOR FOREIGN TRRAINED DOCTORS

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

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

   Male ☐ Female ☐ 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 NRCD 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

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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 ______________

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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).
- ❑ Transcript
- ❑ Passport Photograph
- ❑ Passport
- ❑ Registration Fees
- ❑ C.V/Resume

Applies to Foreigners ONLY

- ❑ Certificate of Good Standing or Current license to Practice
- ❑ Residence Permit

Specialists ONLY

- ❑ One hour orals. No written. Must meet the credentials committee about three weeks to exams.

***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 …………/…………/……………

Approved: Yes ☐ No ☐ Date: ………/………/………

Index Number …………………………….

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