[MDC/CPD FORM A]

MEDICAL & DENTAL COUNCIL

"Guiding the Profession, Protecting the Public"

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)
APPLICATION FOR PROVIDER CERTIFICATION

1. Application for Certification for the Year: January ________ to December _________

2. Name of Provider: ……………………………………………………………………………………..

3. Address: (i) Location:……………………………………………………………………………………
   (ii) Contact:….………………………………………………………………………………...
   (iii)Telephone:…………………………………………………………………………......

4. Type of Body/Organization: (Provider Category)
   - ☐ Academic
   - ☐ Trade Union
   - ☐ Health Related Professional Body
   - ☐ Non-Health Related Professional Body
   - ☐ Other (Specify)

5. Have you been a previous certified Provider? Yes ☐ No ☐

6. Anticipated number of events to be held per year:…………………………………

7. Facilities to be used for CPD Programme e.g. *Hospital Premises, Hotel, Rented Conference Facilities*

8. Name of Contact Person:……………………………………………………………………………..

9. Signature of Contact Person: ………………………………….. Date: …………/…………/………..

For office use only

Received by:……………………………………………………………….. **Date**: …………/…………/……….

Director's Comments:…………………………………………………………………………………………………..

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Signature:………………………………………………………………………… **Date**: …………/…………/……….

Certification Approved: Yes☐ No ☐ **Date**: …………/…………/……….

No. of events organized for the year:…………………………….