



MEDICAL AND DENTAL COUNCIL

"Guiding the Professions, Protecting the Public"



MEDICAL AND DENTAL COUNCIL ELECTION NOMINATION FORM

We, the undersigned, Medical and Dental Practitioners, Physician Assistants or Certified Anaesthetists do hereby nominate the following person to represent Medical/ Dental/Physician Assistants/Certified Anaesthetists. **(Underline where applicable)**

| SURNAME | OTHER NAMES | ADDRESS |
|------------------------|-------------|---------|
| | | |
| Contact Number: | | |

2. **Proposer:** Name:..... **Address:**.....
Signature:..... **Contact No.:**.....

Seconder: Name:..... **Address:**.....
Signature:..... **Contact No.:**.....

3. I the undersigned, Medical/Dental/Physician Assistant/Certified Anaesthetist hereby support the nomination of.....
Supporter: Name:..... **Address:**.....
Signature:..... **Contact No.:**

I, the undersigned, Medical /Dental/Physician Assistant/Certified Anaesthetist Practitioner registered, hereby consent to my nomination for election to the Medical and Dental Council as a representative of Medical/Dental/Physician Assistant/Certified Anaesthetist.

.....
Signature

.....
Date