APPLICATION FOR LICENTIATE EXAMINATION

PHYSICIAN ASSISTANTS

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

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

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Specialty</th>
<th>Dates</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Received by:</th>
<th>Date _<strong><strong>/__<strong>/</strong></strong></strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Checked by:</td>
<td>Date _<strong><strong>/__<strong>/</strong></strong></strong></td>
</tr>
<tr>
<td>Amount Paid:</td>
<td>Date _<strong><strong>/__<strong>/</strong></strong></strong></td>
</tr>
<tr>
<td>Receipt No.:</td>
<td>______________________</td>
</tr>
<tr>
<td>Registrar’s Comments:</td>
<td>______________________</td>
</tr>
<tr>
<td></td>
<td>______________________</td>
</tr>
<tr>
<td>Approved: Yes [ ] No [ ]</td>
<td>Index No. _______________</td>
</tr>
</tbody>
</table>