PHYSICIAN ASSISTANTS

Application for **PERMANENT** Registration
1. **Name in full:**
   
   Surname  First Name  Other Names
   
2. **Previous Name(s):**
   
   Surname  First Name  Other Names
   
3. **Sex:**  Male □  Female □
   
4. **Birth Date:** __________  **Birthplace:** __________  **Nationality:** __________
   
5. **Mailing Address:**
   
   __________________________________________________________
   
   City/Town  Region
   
6. **Contact Numbers:**
   
   __________________________________________________________
   
7. **Email Address:**
   
   __________________________________________________________
   
8. **Home/Permanent Address (if different from above):**

   __________________________________________________________
   
   City/Town  Region
   
9. **Contact Numbers:**

   __________________________________________________________
   
10. **Email Address:**

   __________________________________________________________

11. **School(s)/College(s) University Attended**

   i.  ________________________________  from__/__/____ to__/__/____
       
       Institution  D  M  Y  D  M  Y

   ii. ________________________________  from__/__/____ to__/__/____
       
       Institution  D  M  Y  D  M  Y

   iii. ________________________________  from__/__/____ to__/__/____
       
       Institution  D  M  Y  D  M  Y
12. **Qualification(s) for Registration**

i. ________________________________________  ____/____/______  _______________________
   Degree/Diploma                      Date Granted                   Granting Institution

ii. ________________________________________  ____/____/______  _______________________
    Degree/Diploma                      Date Granted                   Granting Institution

iii. ________________________________________  ____/____/______  _______________________
     Degree/Diploma                      Date Granted                   Granting Institution

13. **Have you ever been found guilty of any criminal offence?**  Yes ☐  No ☐
   If Yes, provide details inclusive of date, court and offence: ________________________________________

14. **Referees:** *(Referees should be in practice for at least 8 years and should be in Good Standing with the Council)*

i. **Name** __________________________________________
   **Address:** __________________________________________
   **Tel. No:** ___________________________ **Fax** ___________ **E-Mail:** __________________________

ii. **Name** __________________________________________
    **Address:** __________________________________________
    **Tel. No:** ___________________________ **Fax** ___________ **E-Mail:** __________________________

15. **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 be cause for refusal or revoking of registration.

   **Signed** ___________________________  **Date:** __/____/______  **Day** ____ **Mth.** ____ **Year**

16. **In pursuance of this application I enclose:**
   - Diploma(s) & Certificate(s) Certified Copy each *(Originals should be available for inspection)*
   - Passport Photograph
   - 2 letters of Reference *(Referees should be in practice for at least 8 years and should be in Good Standing with the Council)*.
   - Registration Fees
17. **Category:**

- I. Medical/Physician Assistant
- II. Anaesthetist Assistant
- III. Community Oral Health Officer

18. **Work Experience:**

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19. **Other Experience:**

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