MDCG FORM 4

Place Passport picture using paper clip. Write your name at the back of picture

MEDICAL AND DENTAL COUNCIL OF GHANA
APPLICATION FOR TEMPORARY REGISTRATION

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

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

Male ☐ Female ☐ Mr. ☐ Mrs. ☐ Miss ☐ Prof ☐ Rev. ☐

Birth Date: ___/____/____ Birthplace: _____ Nationality: _____
City Country

Working Address: _____

_____
City/Town Region

(_____)_____(_____)_____(_____)_____
Tel. Ext. Fax Mobile E-Mail

2. Home/Permanent Address (If different from above): _____

_____
City/Town Region/Country

(___ ___)_____(_____)_____(_____)_____
Tel. Ext. 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 Pre-registration House Officer/Intern:

Hospital	Specialty	Dates		Duration
		Start	End	

8 Other Experience:

Hospital	Specialty	Post/Rank	Dates		Duration
			Start	End	

9 Specialty if any: _____

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).
- ❑ Passport Photograph
- ❑ 2 Letters of Reference(Referees should be in practice for at least 8 years or of the status of Principal Medical Officer and be in Goodstanding with the Council).
- ❑ Registration Fees
- ❑ Letters of Experience
- ❑ Certification of Good Standing or Current license to Practice (applicable to all applicants not
- ❑ C.V./Resume provisionally registered with Council)
- ❑ Letter from **Regional Director of Health Services (RHDS)** of the Region in which the Practitioner would be working
- ❑ **Evidence of selection for employment**

EVIDENCE OF SELECTION FOR EMPLOYMENT/ENGAGEMENT
***(TO BE COMPLETED BY EMPLOYING AUTHORITY*)**

CERTIFICATE OF SELECTION FOR EMPLOYMENT/ ENGAGEMENT

An authorized officer of Hospital authority or sponsoring institution by which the applicant is to be employed must sign this certificate.

It is hereby certified that……
(Name of applicant)

by whom this application is made, has been selected for employment/engagement in a medical/dental capacity (this is in the capacity of a practitioner of medicine, dentistry, surgery other - specify) in the under-mentioned Hospital or Institution (Full name and address, of the Hospital or Institution must be given and if more than one Hospital or Institution is involved, each must be specified).

……

……..……

……..

Description of post of applicant ……

Period of employment/engagement …… from _____/_____/_____ to ____/_____/_____
Day M Y Day M Y

Name ……Official position……..

Signature……Date: ……

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 ……/…….……/……

Chairman's Approval ……..……

…….

Signature …….. Date ……..…/…….……/……

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

Registration Number …….

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