MEDICAL COUNCIL OF GUYANA

APPLICATION FOR REGISTRATION

NAME: ……..

SURNAME FIRST NAME OTHER

DATE OF BIRTH: …… SEX: ……. Phone No: ……..

ADDRESS: …….

Lot No. Street Dist. /Ward Town/Village Region

NATIONALITY: ……..... MARITAL STATUS: ……..

TYPE OF REGISTRATION: Full ( ) Institutional ( ) Internship ( ) Short-Term ( )

QUALIFICATION/S: ……..

DEGREE UNIVERSITY COUNTRY YEAR

ADDITIONAL QUALIFICATION: …….

SPECIALTY: …….

TYPE COUNTRY YEAR

PASSPORT NUMBER: …….. EXPIRATION DATE OF PASSPORT: ……

CITIZEN OF: ……..

COUNTRY OF REGISTRATION AS A MEDICAL PRACTITIONER: …….

DATE OF REGISTRATION: …… EXPIRY DATE OF REGISTRATION: …….

HAVE YOU EVER BEEN THE SUBJECT OF AN INQUIRY OR AN INVESTIGATION BY YOUR LICENSING AUTHORITY INVOLVING AN ALLEGATION OF PROFESSIONAL MISCONDUCT, MALPRACTICE, INCOMPETENCE, INCAPACITY OR ANY LIKE ALLEGATION?

DOES YOUR NAME APPEAR IN THE RECORDS OF YOUR LICENSING AUTHORITY AS HAVING BEEN SUBJECT TO REDUCED, SUSPENDED OR CANCELLED PRIVILEGES BY A HOSPITAL DUE TO INCOMPETENCE, NEGLIGENCE, INCAPACITY OR ANY FORM OF PROFESSIONAL MISCONDUCT/MALPRACTICE?

E-MAIL ADDRESS: …… SIGNATURE: ……