UGANDA MEDICAL AND DENTAL PRACTITIONERS
COUNCIL,P.O.BOX 16115, KAMPALA TEL/FAX 256-41-345844

APPLICATION FORM

I. INFORMATION ABOUT THE APPLICANT

1. Surname……

2. Other names:……

…… ……

3. Nationality:…… ……..

4. Sex:…… ……..

5. Date, Month and Year of birth:

……

6. Marital Status
(single/married/divorced/widowed)……..……

7. Profession (state whether medical or dental doctor)……

…… ……..

8. Current employer:……

9. Country of Birth:……

10. Present Permanent address:…….. ……

…… ……..

……

11. Understanding of spoken/written English: (tick one)
    1. Excellent
    2. Good
    3. Fair
    4. None

12. Other languages: ……

Note: (i) Attach two clear passport size own latest photographs (black and white in colour)

(ii) In case of married female doctors who are using husband's names, attach Certified/Notarised copies of Marriage Certificate.

(iii) Attach detailed curriculum vitae

II REASONS FOR APPLICATION

13. Category of Registration applied for:(tick one)
    - Provisional registration
    - Full registration (2 years or more)
    - Limited Temporary Registration (3 months or less)
    - Temporary registration (4-23 months)

14. Purpose:……

15. Employment commencing on …… ……

    ……..

16. Intended Employer:…… ……

    ……..

17. Address of Employer:……..…….

    ……

18. Telephone/Fax of Employer……..

    ……..

III UNIVERSITY EDUCATION

19. Universities attended for medical or dental education

UNIVERSITY	COUNTRY	AWARD	State Clearly whether Award is a Degree, Diploma, or Certificate	Years attended

Note: Certified/Notarised copies of above award, Academic transcripts and Course Content must be attached.

20. State country and hospitals where internship was done:

…… ……

21. State medical/dental major fields of internship and time spent in each.

FIELD	DURATION
…….. ……	……
……	……
……	……
……	……

Note: Attach evidence that internship was done.

22. Are you a registered medical/dental practitioner?

Yes ☐ No ☐

Note: Attach Certificate/Notarised copy of your current registration Certificate with the Council, Board or equivalent medical/dental Regulatory body of a country where you have been practicing previously in the immediate past years.

IV. EMPLOYMENT RECORD

Evidence of practice for the last five years.

Name of Employer	Duration (from…to…..)	Nature of practice

23. Do you have a certificate of Good Standing in medical or dental practice issued by a Council, Board or equivalent medical/dental regulatory body of the country where you are currently practicing or where you have been practicing in the immediate past years?

Yes ☐ No ☐

V. DECLARATION

I, the undersigned, do hereby certify that under the Medical And Dental Practitioners' Statute of 1996 of the Laws of Uganda, the responses given by me to all the above questions, are true and correct.

…… …… ……..

Name Signature Date