MDCG FORM 4

Place Passport picture usAing 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 ☐ Miss. ☐ Mrs. ☐ Dr. ☐ 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).
- ❑ 1 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 **($600)**
- ❑ 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: ..../...../.....

MEDICAL AND DENTAL COUNCIL
CHECK LIST FOR TEMPORARY REGISTRATION

Name of Practitioner: .....

	YES	NO
1. Diploma(s) / Certificate(s) – Certified (Notarized) Copy (ies).	☐	☐
2. 1 Passport Photograph	☐	☐
3. 2 Letters of Reference	☐	☐
4. Registration Fees ($600)-For 2013	☐	☐
5. Letters of Experience	☐	☐
6. Certificate of Good Standing or Current license to Practice (applicable to all applicants not provisionally registered with Council)	☐	☐
7. C.V./Resume	☐	☐
8. Letter from **Regional Director of Health Services (RHDS)** of the Region in which the Practitioner would be working	☐	☐
9. Evidence of selection for employment	☐	☐

Signed .....

Name of Officer .....

Date: ...../...../.....

Useful Addresses

1. The Registrar
   Medical and Dental Council, Ghana
   P. O. Box AN 10586
   Accra-North

   Tel: +233 302 661620
   +233 302 661606
   Fax: + 233 302 661626
   Emails: education@mdcghana.org
   registrar@mdcghana.org
   mdcaccra@yahoo.co.uk
   Website: www.mdcghana.org

2. The Director
   Human Resource for Health Development
   Ministry of Health
   P. O. Box M44
   Accra.
   Tel: +233 302 674393 / 684250

3 The Director General
   Ghana Health Service
   PMB
   Ministries
   Accra
   Tel: +233 302 662014
   Fax:+ 233 302 666808

4. The Director
   Human Resource Development Division
   Ghana Health Service
   PMB
   Ministries
   Accra
   Tel: +233 302 661354
   Fax: +233 302 670329