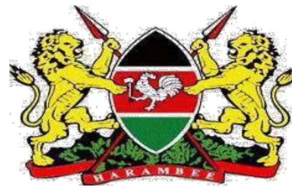

REPUBLIC OF KENYA

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL
THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(CAP 253, SECTION 6)

FORM II
APPLICATION FOR TEMPORARY REGISTRATION AS A MEDICAL OR DENTAL PRACTITIONER

1. Surname ....First Name...................................Other Names...

2. Date of Birth...Nationality...

3. Passport Number...

4. Address.................Code...............................Town.......................County...........................Cell Phone...............................

5. Email...

6. Academic Qualifications:

LEVEL	University/College	Acquired Qualifications	Date
Basic			
Secondary			
Tertiary			

7. Name of Internship Training Centre..Email...

   Period of internship from..to...

8. Name of employer..(Attach Evidence)

   Address.................................Code................................Town.......................County..

- ***a) Internship Completion Certificate downloadable from www.medicalboard.co.ke if applicable.***
- *b) Identification (Passport)*
- *c) Coloured passport size photo*
- *d) Certified copies of professional & academic certificates (translated by the respective Embassy)*
- *e) Evidence of passing Council's pre-registration examination, Peer Review Certificate*
- *f) Dully filled, stamped and signed Internship completion Assessment Forms if applicable*
- *g) Evidence of registration or practice licence from country of origin*
- *h) Certificate of status by regulatory body from country of origin*
- *i) ECFMG Certification*
- *j) Registration Fee Kshs.20,000*

*All payments should be made at any **KCB Branch** countrywide to Council's account No. **1103158643, Milimani Branch. SWIFT CODE: KCBLKENX, BANK: KCB, BANK CODE: 01175***

I hereby certify that the above information is correct to the best of my knowledge and that I have met the above requirements. Signature of Applicant:...Date ....

FOR OFFICIAL USE
The process will take a maximum of two weeks.

	APPROVED/NOT APPROVED
PREPARED: Name:..Designation.................................	Practice Type: GP... SP...
Signature.......................................Date..	Name...
RECOMMENDED:	Designation...
Signature.......................................Date..	Signature..
	Date..