# MEDICAL AND DENTAL COUNCIL

*"GUIDING THE PROFESSION, PROTECTING THE PUBLIC"*

## MEDICAL AND DENTAL PRACTITIONERS

## REVALIDATION FORM

Place Passport picture **(WHITE BACKGROUND ONLY)** using paper clip. Write your name at the back of picture

NAME OF PRACTITIONER: ……

MDC REG. NUMBER ……

EMAIL: …… MOBILE NO……

POSTAL ADDRESS: ……..……..

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COUNTRY OF PRACTICE ……..

INSTITUTION OF PRACTICE/WORK: ……..

FACILITY TYPE: Teaching Hospital [ ] GHS [ ] CHAG [ ] Quasi-Govt. [ ] Private [ ]

LOCATION: Region: ……..…… District: …..……..

NAME OF NEXT OF KIN ……

NEXT OF KIN RELATION …… MOBILE NO……

NEXT OF KIN EMAIL ADDRESS ……..

PERMANENT ADDRESS OF NEXT OF KIN ……...

……..

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## PHYSICIAN ASSISTANS & CERT. REG. ANAESTHETISTS

Place Passport picture **(WHITE BACKGROUND ONLY)** using paper clip. Write your name at the back of picture

## REVALIDATION FORM

NAME OF PRACTITIONER: ……

MDC REG. NUMBER ……

EMAIL: …… MOBILE NO……

POSTAL ADDRESS: ……..……..

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COUNTRY OF PRACTICE ……..

INSTITUTION OF PRACTICE/WORK: ……..

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