

بِسْمِ اللّٰهِ الرَّحْمٰنِ الرَّحِیْمِ



Maldives Medical Council
 Ministry of Health , Male' , Republic of Maldives
Application for Medical Registration Exam

Notice: 1-Please use BLOCK letters to completing this application form
 2-Recent Passport size photo

Serial No:
 Receipt no:

I PERSONAL DETAILS

Name: Sex: F M

Date of Birth: ID Card No:

Nationality: Contact Tel No :

Permanent Address:

Current Address:
(If different from above)

E- Mail Address:

Number of attempt for the licensing Exam

*please paste a
 recent passport size
 photograph
 here*

(B) PROFESSIONAL QUALIFICATIONS (MBBS)

Qualification	Institute	City / Country	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

IV DOCUMENTS TO BE SUBMITTED

- 1.MMC provisional registration Copy
- 2.PP copy/ID card Copy

Declaration by Applicant

I hereby declare that the information provided by me in this application is true to the best of my knowledge.

Signature: _____

Date : day/month/year

For Official Use

Provisional Registration Number at Maldives Medical Council:

Registered as:

Date : day/month/year

Signature :

Designation :