THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(CAP 253)
APPLICATION FOR RENEWAL OF INSTITUTIONAL LICENCE FOR THE YEAR 2016

(***All fields are required , cancel where not applicable***)
PART (1)

Details of the Facility

1. Name of the Facility:.....

   P.O Box ..... Code .....Town .....

   Tel No. ..... Mobile No.....

   Email address: .....

2. Physical Location of institution:

   County: .....Sub County.....District: .....

   Division: ..... Town/ market: .....

   Building/ Plot No: ..... Street: .....

3. Registration Number: .....Date of Registration:.....

4. Previous License Number: .....

5. Type of institution: .....

6. No. of Beds: .....

7. Availability of ICU. (YES/NO). If Yes, indicate the number of Beds: .....

8. Fees payable: .....

9. Names of medical personnel (Kindly attach full list):

   Doctor in charge: ..... Reg. No. .....

   Other doctors: 1. ..... Reg. No. .....

   2. ..... Reg. No. .....

   Clinical Officers: 1. ..... 2.....

   3. ..... 4.....

   5. ..... 6.....

   Nurses: 1. ..... 2.....

   3. ..... 4.....

   5. ..... 6.....

Lab. Technicians/ Technologists: 1. .....

2. .....

(f) Pharmacists/ Pharmtechs: 1. .....

2. .....

Others: 1.....

2. .....

9. Applicant's full names: .....

10. Designation: .....

11. **Late payment attracts 50% penalty.**

12. Signature: ..... Date: .....

All payments should be made at any KCB Branch countrywide to Medical Practitioners and Dentists Board account No. 1103158643, Milimani Branch.

PART (2)

FOR OFFICIAL USE:
Delete where inapplicable

PREPARED:

Name.....

Designation.....

Signature.....**Date**.....

RECOMMENDED:

Name.....

Designation.....

Signature.....**Date**.....

APPROVED/NOT APPROVED

Name.....

Designation.....

Signature.....

Date.....

Physical Address: MP&DB House- Woodlands Rd off Lenana Rd

Address: P.O Box 44839-00100, NAIROBI-Kenya

Email: info@kenyamedicalboard.org

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