PHOTO

REPUBLIC OF KENYA

THE MEDICAL PRACTITIONERS AND DENTISTS ACTS
(NO.20 of 1977)
APPLICATION FOR INTERNSHIP QUALIFYING EXAMINATION/FOR FOREIGN TRAINED DOCTORS/EAST AFRICA COMMUNITY RECIPROCAL RECOGNITION

1. Surname ……Other Names ……
2. Date of Birth……Nationality……
3. Address……Code……Town……Tel……
4. Email……
5. Degree, Diploma or Licence held (*give name of medical school and date qualified – if degree not in English, provide official translation)*

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Requirements

(i) Copy of ID/Passport
(ii) Coloured pass port size photo
(iii) Certified copies of professional certificates
(iv) Curriculum Vitae
(v) Qualification; Form IV or VI Certificate
(vi) Must be attached at a training institution approved by the Council for a period of 4 months.
(vii) Evidence of appropriate linguistic skills in English and/or Kiswahili for non-Kenyans
(viii)Evidence of registration from EAC Partner States Board's and councils (for those applying for reciprocal registration)
(ix) Letter from Commission for University Education (CUE) confirming recognition of the medical/dental school (if foreign trained)
(x) ECFMG Verification Form
(xi) ***Application fee Kshs. 5,000.00***
(xii) ***Examination/Evaluation of qualification papers Kshs.30,000.00***

(Payments should be made to Medical Practitioners and Dentists Council Account No: 1103158643, KCB Bank, Milimani Branch or SWIFT CODE: KCBLKENX BANK CODE: 01175)

I hereby certify that the above information is correct to the best of my knowledge and I have fulfilled all the above requirements.

Signature……Date……

FOR OFFICIAL USE:

PREPARED BY: -	**APPROVED/NOT APPROVED**
Name:……Designation……	Name……
Signature……Date……	Designation……
CHECKED BY: -	Signature……
Name:……Designation……	Date……
Signature……Date……	

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