

CONFIDENTIAL

**MEDICAL COUNCIL OF ZAMBIA
P O BOX 32554
LUSAKA
Tel: 236241 Fax: 239317**

E mail mcz@iconnect.zm Website: www.medicalcouncilofzambia.org.zm

**APPLICATION FOR FULL REGISTRATION
(Medical and Allied Professions Act, Cap. 297 of the Laws of Zambia)**

1. Surname of applicant: Mr/Mrs/Miss/Dr.....
2. Other Names:
3. Date of Birth: Sex:
4. Nationality:.....Citizenship:.....
5. NRC or Passport No.:.....
6. Phone No..... E mail Address.....
7. Residential Address:
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8. Postal Address:
-
9. Name and Address of prospective employer:
-
10. Profession of applicant:
11. Dates and No. of Temporary/Provisional Registration:

I hereby apply for full registration with the Medical Council of Zambia.

.....
SIGNATURE DATE

- NB:** 1. The fee for full registration is K..... Plus K.....annual fee.
Duly completed form must be sent or delivered to the Medical Council by the Head of Institution or approved supervisor.
2. This application should be accompanied with a recommendation letter from the head of the Institution

To be completed and returned to the council in confidence by the Medical Officer in charge of internship hospitals recognised by the council).

1. Details of Rotary Internship:

Name of speciality	Scheme A-Duration From	Name of Consultant To
Medicine
Surgery
Obstetrics and Gynaecology
Paediatrics

Name of speciality	Scheme B-Duration From	Name of Consultant To
Medicine
Obstetrics, Gynaecology and Paediatrics

2. Comments on the performance and conduct of the intern:

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I declare that the information given above is true and accurate to the best of my knowledge and I RECOMMEND/DO NOT RECOMMEND the applicant for full registration.

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FULL NAMES OF HEAD OF INTERNSHIP HOSPITAL	SIGNATURE	DATE