MEDICAL AND DENTAL PRACTITIONERS COUNCIL OF ZIMBABWE

8 Harvey Brown
Milton Park, Harare
Fax: 792197
Cell No: 0912 261 612
E-mail : mdpcz @ healthnet.zw

P.O Box CY2817
Causeway
Harare
Telephone 792195

APPLICATION FOR TRANSFER FROM PROVISIONAL TO PERMANENT REGISTER

(Complete in block letters)

1. FULL REGISTERED NAME ..... SURNAME ..... FORENAMES .....

MR / MISS / MRS .....

2. REGISTERED ADDRESS .....

3. PROVISIONAL REGISTRATION

(a) PROFESSION .....(b) REGISTRATION No .....

4 **FULL DETAILS OF EMPLOYMENT DURING PERIOD OF PROVISIONAL REGISTRATION**

NAME OF EMPLOYER	DATES OF EMPLOYMENT	CAPACITY IN WHICH EMPLOYED
.....	.....	.....
.....	.....	.....
.....	.....	.....

5. NAMES OF TWO PERSONS FROM WHOM PROFESSIONAL REFERENCE IN THE FORM ATTACHMENTS HAVE BEEN REQUESTED

IT SHOULD BE NOTED THAT THE TWO PERSONS NOMINATED MUST BE PERSONS WHO ARE CURRENTLY REGISTERED WITH THE MEDICAL AND DENTAL PRACTITIONERS COUNCIL COUNCIL AND SHOULD BE **SENIOR SUPERVISING PERSONNEL** OF THE SAME OR SIMILAR PROFESSIONALS AND UNDER WHOM THE APPLICANT HAS WORKED FOR A MINIMUM PERIOD OF SIX MONTHS IN ZIMBABWE.

6. (1) ..... (2) .....

7. TRANSFER FEE

This application must be accompanied by a fee of $..... and sent to the REGISTRAR MEDICAL AND DENTAL COUNCIL , P.O BOX CY 2817, CAUSEWAY, HARARE.
PROVISIONAL REGISTRATION FOR A PERIOD OF THREE YEARS, FOUR MONTHS BEFORE THIS EXPIRES PERSONS MUST MAKE APPLICATION FOR THEIR NAMES TO BE TRANSFERED TO THE MAIN REGISTER.

8. PLEASE NOTE

PERSONS WHO FAIL TO APPLY FOR TRANSFER WILL HAVE NAMES REMOVED FROM THE RELEVANT REGISTER ON COMPLETION OF THE THREE YEAR PERIOD AND THEREAFTER ARE LIABLE TO PROSECUTION IF PRACTISING WHILST NOT REGISTERED.

9. SIGNATURE OF APPLICANT .....

MEDICAL AND DENTAL PRACTITIONERS COUNCIL

REPORT AND RECOMMENDATION

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1. APPLICANT

(a) Full name (MR/MRS/Miss/Dr).....

(b) Capacity in which known to you in Zimbabwe .....

.....

Period known to you From ..... To : .....

(c) Professional knowledge and practical ability .....

.....

.....

2. REPORTING OFFICER

(a) Full Name (Mr/Mrs/Miss) .....

(b) Address .....

(c) Registered Qualification(s).....

(d) Professional Positional position held .....

(e) Signature .....

(Please insert official hospital stamp)

This form be returned to :

THE REGISTRAR
MEDICAL AND DENTAL PROFESSIONALS COUNCIL
P.O BOX CY 2817 CAUSEWAY
HARARE

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