GRENADA MEDICAL AND DENTAL COUNCIL

APPLICATION FOR REGISTRATION

Address: P.O. Box: 3323, St. George **E-mail**: grenadamedcouncil@live.com
Phone: 1 (473) 459-2384 / 444-2384

Personal Information:			
Full Name:			
Date Of Birth (mm/dd/yy):		Gender: Male ☐ Female ☐	
Place Of Birth:		Citizenship:	

Contact Information:	
Mailing Address	
Office Address	
E-mail Address	
Tel. Numbers	Office: Cellular:

General Information:		
Institution Of Medical Graduation:		End Date:
Institution Of Medical **Post** Graduation:		End Date:

Exact Title of Post-Graduation Degree/ Diploma (If Applicable)	
Country or Counties Where Currently Registered	
Date of Expiration of Current Registration:	
Reason For Application:	
Present Employer and Post	

GRENADA MEDICAL AND DENTAL COUNCIL

APPLICATION FOR PRACTISING CERTIFICATE

Address: P.O. Box: 3323, St. George **E-mail**: grenadamedcouncil@live.com
Phone: 1 (473) 459-2384 / 444-2384

Personal Information:	
Name:	
Details of Any Change of Name:	

Contact Information:		
Mailing Address		
Office Address		
E-Mail Address		
Tel. Numbers	Office:	Cellular:

CLASSIFICATION OF REGISTRATION:		
General Practitioner ☐	Consultant ☐	Specialist ☐

Details of Continuing Medical Education Courses Taken in Last Three (3) Years (Attach Copies)	

Signed ……

APPLICANT