NOTIFICATION OF EMIGRATION

Surname: ____________________________________________________

First /Other Names: ____________________________________________________

(Estimated) Date of Emigration: ___________   ________ _________
(Month)   (Day)  (Year)

(Estimated) Date of Return to Trinidad: ___________   ________ _________
(Month)   (Day)  (Year)

Country emigrated to : _______________________________

State/Province (optional): ________________________________

Check one option
Reason for emigration:

☐ Employment  ☐ Post-graduate training  ☐ Migration (not expected to return)

☐ Other: Please specify ________________________________________________________

Date:______________________   Signature:__________________________

Kindly mail this form to: Medical Board of Trinidad & Tobago
Building F2
Eric Williams Medical Sciences Complex
Champs Fleurs
Trinidad, W.I.

Or fax it to (1-868)-645-5826.