

APPLICATION FOR FULL REGISTRATION WITH THE MEDICAL BOARD OF TRINIDAD AND TOBAGO

Kindly indicate YES or NO to question 5 below, if YES please enter details.

5. Have you ever been reviewed of your conduct, competence or capacity or fitness to practice, whether arising from a complaint or otherwise in another jurisdiction? YES NO

IF YES: Date of review: Country: State/Providence: Name of Medical Board/Council:

Explanation of above Medical Board/Council's review in relation to your conduct/ competence/ capacity to practice medicine/ fitness to practice medicine. (Circle the appropriate category above)

6. List all other Medical Councils/Organizations where you are registered? i ii iii iv v vi vii viii ix x

7. I hereby agree that I have read the Code of Ethics online (www.mbtt.org) Yes No

I, hereby apply for (Name in Block Letters)

Full Registration with the Medical Board of Trinidad and Tobago, by virtue of the following qualifications of which I am lawfully possessed.

Table with 2 columns: Description of Qualifications, Date of Qualifications

Place and Date of Applicant's Birth Applicant's Ordinary Address

I DO HEREBY CERTIFY THE ABOVE INFORMATION TO BE TRUE

Date of Application Signature

Applicant must submit with this Application:-

- Satisfactory Evidence of Identity (Passport, Driver's Permit or National Identification Card). Satisfactory Evidence of Good Character. Qualifying Diploma and a Certificate or Letter of Good Standing from your last Registration body not more than three (3) months old. Two (2) passport size photographs (if not previously produced to the Medical Board of Trinidad & Tobago). Prescribed Fee of Two Thousand Dollars (\$2000.00) - (\$1000.00 Registration Fee and \$1000.00 license to practice for the current year).

Receipt No. Certificate No. Date Issued

CERTIFICATE OF GOOD CHARACTER

Kindly indicate **YES** or **NO**, if **YES** please enter details

4. **YES** **NO**

Are you currently or have you been under investigation or other proceeding in relation to your conduct, competence or capacity or fitness to practice medicine in another jurisdiction?

IF YES:

Date of investigation/proceeding: _____

Country: _____ State/Providence: _____

Name of Medical Board/Council: _____

Explanation of above Medical Board/Council's investigation/proceeding in relation to your conduct/ competence/ capacity/ fitness to practice medicine.
(Circle the appropriate category above)

I,

(Name in Block Letters)

residing at

.....

hereby certify that I have known the applicant:

.....
(Name of Applicant)

for the past years. I further certify that he/she is of good character and a fit and proper person to be admitted to the medical profession in Trinidad and Tobago.

Signature

Qualifications

Date

N.B. The signatory must be well acquainted with the applicant for at least five (5) years and be a Physician registered to practice medicine.

