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BAHAMAS MEDICAL COUNCIL

Application Form for Registration Under Section ____

Name in full:____
(Surname) (Given Name)

Date and Place of Birth:____

Nationality: Age: Sex: Marital Status:

Telephone: (Home) (Work) (Cell)____________

Email Address:____

Postal Address: (Home)____

Postal Address: (Work) ____

Name, Postal Address & Telephone Number of a local contact person:

____

____

1. Document certifying citizenship (passport, birth certificate or affidavit)
2. Medical Degree, Name & Place of the Medical School, Date Degree Obtained. (Enclose original diploma or notarized copy):
   ____
   ____
   ____
   ____
3. Copy of Notarized Registration and current Medical Licence
4. List of Additional and/or Higher Qualifications - full particulars and dates. (Enclose original diplomas or notarized copies):
   ____
   ____
   ____
   ____
5. Include current Certificate of Good Standing
6. Include Employee Contract or Employment Letter

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7. Have any proceedings ever been initiated against you in a court of law or by a medical licensing authority? (Yes or No, if yes provide details):
   ____
   ____

8. State type of practice you wish to pursue:
   ____

9. Professional References: Include 3 current references with full postal address:
   ____
   ____
   ____
   ____
   ____

I declare that I can read, write, speak and understand the English Language, and that the information contained in this application is true and correct. Should any changes occur in the documentation presented with my application I shall promptly notify the Council of the changes.

Signature of Applicant:______________________

Date: ______________________________________

BAHAMAS MEDICAL COUNCIL

Mailing Address:
79 Collins Ave
2nd Floor
P.O. Box N-9802
Nassau, Bahamas

Telephone No:
(242) 323-0342

Fax No:
(242) 323-0344

Office Hours:
Mondays - Friday
9:00am – 5:00 pm