REPUBLIC OF KENYA

(Cap.253)

MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

APPLICATION FOR

REGISTRATION AS A MEDICAL/ DENTAL STUDENT

(Please use
block letters and return to the addresses provided at the end)

TO BE DULY COMPLETED BY THE STUDENT

1: PERSONAL DETAILS

Surname ……First Name……Middle Name……

ID No……Passport No……Country of issue……

Postal address ……Code……Town……County……

KCSE Mean Grade……Other if not KCSE……

Mobile No ……Email Address……

Next of Kin (Full Names) ……Email Address…… Telephone Number ……

Date of Birth ☐ (DD/MM/YYYY) ☐ ……

Gender: Male Female Nationality: ……

Name of University……Postal Address ……Postal Code ……Town……

Tel. Number……Email……Country……

Admission Number……

Date of enrollment (DD/ ☐ MM/YYYY) ☐ ……Year of Study……

Course Type: Medicine Dentistry

SIGNATURE:……DATE…… Degree to be

2: REQUIREMENTS

a) Certified copy of the KCSE certificate/ result slip or its equivalent
b) Certified copy of birth certificate and ID or passport
c) Two colored passport size photos
d) Registration fee - Kshs. 1000 (**All payments should be made via*
Medical Practitioners and Dentists Council, KCB Bank Account No: 1103158643, Milimani Branch)

3: FOR UNIVERSITY *(To be completed and stamped by Dean)*

I confirm that the above student with above **adm.no** is a bona fide student of the above institution.

Name……

Date……

Signature……

FOR OFFICIAL USE	**APPROVED/NOT APPROVED**
PREPARED BY: -	Name……
Name:……Designation……	Designation……
Signature……Date……	Signature……
CHECKED BY: -	Date……
Name:……Designation……	
Signature……Date……	

Address: P.O Box 44839-00100, NAIROBI-Kenya

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