



REPUBLIC OF KENYA

**THE MEDICAL PRACTITIONERS AND DENTISTS ACTS (NO.20 of 1977)
APPLICATION FOR INTERNSHIP QUALIFYING EXAMINATION FOR FOREIGN TRAINED
DOCTORS/EAST AFRICA COMMUNITY RECIPROCAL RECOGNITION**

1. SurnameOther Names
2. Date of Birth.....Nationality.....
3. Address.....Code.....Town.....Tel.....
4. Email.....
5. Degree, Diploma or Licence held (give name of medical school and date qualified – if degree not in English, provide official translation)
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6. Next of Kin (Full Names)Email Address.....
Postal Address..... Telephone Number

Requirements

- i. Copy of ID/ Passport;
- ii. 2 Coloured passport size photographs;
- iii. Original and Certified True copies of undergraduate certificates and academic transcripts;
- iv. Qualification: Form IV or VI certificate or its equivalent, equated by the Kenya National Qualifications Authority (KNQA) where applicable.
- v. Verification from Educational Commission for Foreign Medical Graduates (ECFMG).
- vi. Letter from Commission for University Education (CUE);
- vii. Application fee of Kshs. 5,000.
- viii. Evaluation fee of Kshs. 30,000.

NOTE: After complying with the requirements, you will be sent for a mandatory Four (4) Month attachment at a training institution approved by the council.

(Payments should be made to Medical Practitioners and Dentists Council Account No: 1103158643, KCB Bank, Milimani Branch or SWIFT CODE: KCBLKENX BANK CODE: 01175)

NOTE: Original degree certificate, ID and passport must be sighted before application is submitted

I hereby certify that the above information is correct to the best of my knowledge and I have fulfilled all the above requirements.

Signature.....Date.....

FOR OFFICIAL USE:

<p>PREPARED BY: - Name:.....Designation..... Signature.....Date.....</p> <p>CHECKED BY: - Name:.....Designation..... Signature.....Date.....</p>	<p>APPROVED/NOT APPROVED Name..... Designation..... Signature..... Date.....</p>
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