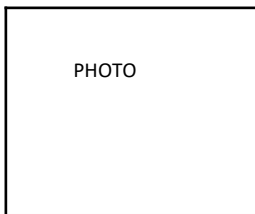




**REPUBLIC OF KENYA
THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap.253)**

APPLICATION FOR RECOGNITION OF SPECIALIST/SUB-SPECIALTY



(All fields are mandatory. Cancel where not applicable)

1. Surname Other Names Reg.No.

2. Date of Birth Nationality

3. Address Code Town County Mobile No.

4. Email

5. Employer

6. Degree, Diploma or License held *(give name of medical school and date qualified)*
.....

7. Specialty/Sub-Specialty applied for

8. Postgraduate qualifications: medical/dental school Date qualified

9. Number of years in practice after Post Graduate Qualification (indicate the number years or months, name of institution (s) attended and name of two supervisors whose address must accompany this application)
No. of Years/Months Name of Practicing Institution County

Supervisors 1) Name P.O Box Code Town County

Email:

2) Name P.O
Box Code Town County

Email:

10. Next of Kin (Full Names) Email Address

Postal Address Telephone Number

Requirements

1. Current Copy of Practice Licence.
 2. Certified Copy of post graduate qualification and official transcripts.
 3. Evidence of completion of 2 year rotations in a recognized institution for specialist recognition or one year rotation in a recognized institution for sub-specialist recognition.
 4. Supportive recommendation from two (2) referees in the relevant specialty.
 5. Specialty and sub specialty must be in the approved list.
 6. Application fee of Kshs.20,000
- All payments should be made: Medical Practitioners and Dentists Board, KCB Bank Account No:1103158643, Milimani Branch**

***Transactions can be undertaken at any KCB Branch countrywide**

Computer generated and stamped banking slip together with should be either emailed to info@kmpdc.go.ke or posted to Medical Practitioners and Dentists Council Office.

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:

This process takes a maximum of two(2) weeks.

PREPARED BY:

Name: Designation

Signature Date

CHECKED BY:

Name: Designation

Signature Date

APPROVED/NOT APPROVED

Specialty /Sub-Specialty

Name

Designation

Signature

Date