PHOTO

FORM VI A

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:	**APPROVED/NOT APPROVED**
Name:……Designation……	**Specialty/Sub-Specialty**
Signature……Date……	Name……
CHECKED BY:	Designation……
Name:……Designation……	Signature……
Signature……Date……	Date……

Physical Address: MP&DB House- Woodlands Rd off Lenana Rd
Address: P.O Box 44839-00100, NAIROBI-Kenya
Email: info@kmpdc.go.ke
Tel: +254 20-272 8752 |+254 20 272 4994 |+254 20 271 1478
Mobile : +254 720 771 478 |+254 736 771 478
Website: www.kmpdc.go.ke