



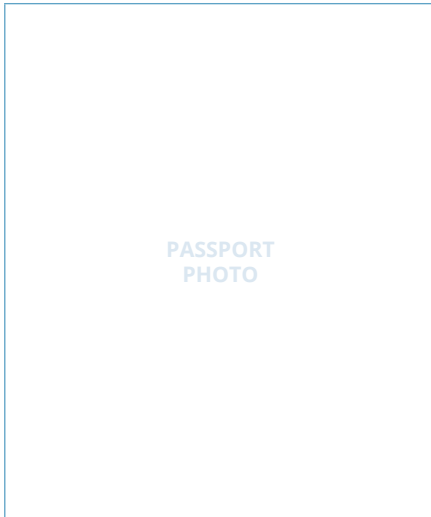
KMPDC
Enhancing Quality Healthcare

FORM – IV

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info@kmpdc.go.ke | www.kmpdc.go.ke

APPLICATION FOR RECIPROCAL REGISTRATION AS A MEDICAL/DENTAL PRACTITIONER BY A CITIZEN OF THE EAST AFRICAN COMMUNITY

PURSUANT TO THE MEDICAL PRACTITIONERS AND DENTISTS ACT (CAP 253 – LAWS OF KENYA)



A. DETAILS OF THE APPLICANT

SURNAME			
OTHER NAMES			
DATE OF BIRTH			
NATIONALITY			
PASSPORT NUMBER			
GENDER			
POSTAL ADDRESS			
CODE		TOWN	
COUNTY			
MOBILE NUMBER			
E-MAIL ADDRESS			

DISABILITY ASSESSMENT

DO YOU HAVE ANY DISABILITY?	YES	NO
IF YES, PLEASE SPECIFY (ATTACH NCPWD CERTIFICATE)		

B. PROFESSIONAL QUALIFICATIONS

EDUCATION

NAME OF MEDICAL/DENTAL SCHOOL				
E-MAIL ADDRESS				
PERIOD OF EDUCATION	FROM		TO	

INTERNSHIP

NAME OF INTERNSHIP TRAINING CENTRE				
E-MAIL ADDRESS				
PERIOD OF INTERNSHIP	FROM		TO	

PARTICULARS AND TESTIMONIALS COVERING THE PERIOD(S) OF EXPERIENCE

NAME OF INSTITUTION	ROLE	POSTING PERIOD

CONFIRMATION OF REQUIREMENTS

1	CERTIFIED COPY OF ID/PASSPORT	
2	ONE CURRENT COLOURED PASSPORT SIZE PHOTOGRAPH	
3	CERTIFIED COPY OF HIGH SCHOOL CERTIFICATE EQUATED BY THE KENYA NATIONAL QUALIFICATIONS AUTHORITY (KNQA)	
4	COPY OF DEGREE CERTIFICATE AND TRANSCRIPTS CERTIFIED BY THE TRAINING INSTITUTION IF NOT IN ENGLISH PROVIDE OFFICIAL TRANSLATION	
5	COPY OF REGISTRATION CERTIFICATE FROM COUNTRY OF ORIGIN CERTIFIED BY THE ISSUING AUTHORITY	
6	ORIGINAL CERTIFICATE OF STATUS ISSUED WITHIN THE LAST SIX MONTHS FROM THE DATE OF APPLICATION	
7	DETAILED OFFER OF EMPLOYMENT FROM A REGISTERED HEALTH INSTITUTION IN KENYA	
8	EVIDENCE OF PAYMENT OF REGISTRATION FEE OF KSH. 80,000 ALL PAYMENTS SHOULD BE MADE ON E-CITIZEN VIA SYSTEM GENERATED INVOICE NUMBER	

NOTE: ORIGINAL DEGREE CERTIFICATE MUST BE PRESENTED FOR VERIFICATION BEFORE PROCESSING OF THIS APPLICATION

C. DECLARATION BY APPLICANT

I HEREBY DECLARE THAT THE ABOVE INFORMATION IS CORRECT AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF

SIGNATURE		DATE	DD	MM	YYYY
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FOR OFFICIAL USE

THE PROCESS WILL TAKE A MAXIMUM OF TWO (2) WEEKS

PREPARED BY

NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY

RECOMMENDED BY

NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY

APPROVED/NOT APPROVED

NAME					
DESIGNATION					
SIGNATURE		DATE	DD	MM	YYYY