BVI MEDICAL AND DENTAL COUNCIL

Application for Registration as a Medical Practitioner or Dentist in the Territory of the British Virgin Islands

Place photograph here

1. Last Name: | | | | | | | | | | | | | | | | | | |

2. FirstName: | | | | | | | | | | | | | | | | | | |

3. Age: _____ 4. Date of Birth (dd/M/Y): ___/ ___/ ____ 5. Email: _____

6. 1 Permanent Address	
Street	
City	
State or Province	
Zip Code	
Country	

Postal Address (Where you want the decision mailed)	
Street	
City	
State or Province	
Postal Code	
Country	

8. Website : _____

9. Contact Tele No: (Home) (_____) _____ _____ 10. (Mobile) (_____) _____ _____

11. Fax number: (_____) _____ _____

12.

	Degree	School/University	Date Degree Received
1			
2			
3			

Internship and Number of Rotations and Durations			
	Name of Institution	No of Rotations	Durations
1			
2			
3			

Other Certifications: _____

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Place photograph here

Employment History

1.
2.
3.
4.

Registration History

1.
2.

Disciplinary Action (Past & Pending):	Date
1.	

Continuing Education
1.
2.
3.
4.

Signed by Applicant (Print) _____ Date: ___/ _____/ _____

Signed by Applicant (Signature) : _____