PHOTO

REPUBLIC OF KENYA

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

1. Surname ……Other Names …… …….

2. Date of Birth……Nationality……

3. Address……Code……Town……Tel……

4. Email……Mobile……

5. Degree, Diploma or License held (*give name of medical school and date qualified – if degree not in English, provide official translation). (Certified True Copies must be provided)*
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6. Particulars of Experience (*e.g. posts held, type of practice in which the applicant has been engaged, countries in which the applicant has practiced:*

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7. Testimonials Covering the Period(s) of Experience

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8. Have any arrangements been made regarding employment? *(if so, give details)*……

Requirements

(i) *Copy of ID/Passport*
(ii) *Coloured passport size photo*
(iii) *Certified copies of Degree Certificate & other professional certificates*
(iv) *Evidence of appropriate linguistic skills in English and/or Kiswahili for non-Kenyans*
(v) *Academic transcripts or Evidence of internship*
(vi) *Must be attached at a Ministry of Health Approved Internship Training Centre for a period of 4 months.*
(vii) *Curriculum Vitae*
(viii) *Evidence of completion of internship or Registration from a Medical Council*
(ix) *Certificate of Status (Good Standing)*
(x) *Letter from Commission for University Education (CUE) confirming recognition of the medical/dental school (if foreign trained)*
(xi) *Qualification; Form IV or VI certificate*
(xii) *Application fee Kshs.5,000.00*
(xiii) *Examination/ Evaluation of qualification papers - Fees Kshs.50,000.00*
(xiv) ***All payments should be made at any KCB Branch countrywide to Council's account No. 1103158643, Milimani Branch.***

Signature of applicant ……Date……

PREPARED BY: -	**APPROVED/NOT APPROVED**
Name:……Designation……	Name……
Signature……..Date……	Designation……
CHECKED BY: -	Signature……
Name:……Designation……	Date……
Signature……..Date……	

Physical Address: KMPDC House- Woodlands Rd off Lenana Rd
Tel: +254 20-272 8752 |+254 20 272 4994 |+254 20 271 1478
Mobile: +254 720 771 478|+254 738 504 112
Address: P.O Box 44839-00100, NAIROBI-Kenya

Email: info@kmpdc.go.ke

Website: www.kmpdc.go.ke