



BOARD OF GOVERNORS
IN SUPERSESION OF MEDICAL COUNCIL OF INDIA
 Pocket - 14, Sector - 8, Phase-I, Dwarka, New Delhi - 110 077
 Phone : 011-25367033, 25367035, 25367036,
 Email : mci@bol.net.in, Website : <http://www.mciindia.org>

APPLICATION FORM FOR GRANT OF TEMPORARY REGISTRATION U/S 14(1) OF THE INDIAN MEDICAL COUNCIL ACT, 1956 TO FOREIGN NATIONALS FOR THE PURPOSES OF POSTGRADUATE TRAINING/COURSE/FELLOWSHIP IN A MEDICAL COLLEGE/HOSPITAL IN INDIA.

(Please read the instructions carefully given in Appendix-I before filling the form.)

Application for Temporary Registration:

1.	NAME OF THE APPLICANT (IN BLOCK LETTERS)	
2.	FATHER'S NAME (IN BLOCK LETTERS)	
3.	PRESENT CORRESPONDENCE ADDRESS	
4.	PHONE, FAX NO. & E-MAIL ADDRESS	
5.	DATE OF BIRTH & NATIONALITY	
6.	NAME OF THE MEDICAL DEGREE/DIPLOMA OBTAINED AND UNIVERSITY WITH THE MONTH AND YEAR OF PASSING THE QUALIFICATION.	
7.	WHETHER PREVIOUSLY VISITED IN INDIA IF SO, DATE, PERIOD AND PLACE OF PREVIOUS	
8.	REGISTRATION PARTICULARS:- (a) ARE YOU REGISTERED IN ANY OTHER FOREIGN COUNTRY? IF SO, GIVE NAME OF THE BODY WITH WHICH REGISTERED AND THE NUMER AND DATE OF REGISTRATION.	

	(b) ARE YOU REGISTERED AS A MEDICAL PRACTITIONER IN YOUR OWN COUNTRY? IF SO PROVIDE THE NAME OF THE BODY WITH WHICH REGISTERED WITH THE REGISTRATION/LICENSE NUMBER AND DATE.	
	(c) WHETHER THE REGISTRATION/ LICENSE IS RENEWABLE OR PERMANENT.	
9.	NAME OF THE HOSPITAL/INSTITUTE IN INDIA WITH COMPLETE ADDRESS FOR POSTGRADUATE TRAINING/COURSE/ FELLOWSHIP IN A MEDICAL COLLEGE/HOSPITAL IN INDIA	
10.	PROPOSED DATE OF POSTGRADUATE TRAINING/COURSE/ FELLOWSHIP	
11.	NAME OF THE PERSON IN THE INSTITUTION/HOSPITAL IN INDIA WHO WILL BE RESPONSIBLE FOR THE LEGAL ISSUES REGARDING THE PATIENT CARE PROVIDED BY THE DOCTOR CONCERNED.	
12.	<u>DETAILS OF FEES:</u> AMOUNT IN INR:	<u>DETAILS OF DEMAND DRAF</u> (a) NAME & ADDRESS OF ISSUING BANK (b) DEMAND DRAFT NO. (c) Date:

SIGNATURE AND STAMP OF THE
HEAD OF THE INSTITUTE/HOSPITAL IN INDIA

SIGNATURE OF THE APPLICANT

DATE: _____

PLACE: _____

APPENDIX-I
INSTRUCTIONS

1. THE APPLICATION FORM SHOULD BE PROPERLY AND NEATLY FILLED IN BY THE APPLICANT AND SHOULD BE SUBMITTED ALONG WITH THE FOLLOWING DOCUMENTS IN 2 (TWO) SETS: -

- a) COPY OF CURRENT REGISTRATION CERTIFICATE IN YOUR OWN COUNTRY DULY ATTESTED. IN CASE, THE DOCUMENTS ARE IN LANGUAGE OTHER ENGLISH THEN TRUE COPY OF THE DOCUMENT(S) ALONGWITH AUTHENTICATED COPY OF THE SAME IN ENGLISH VERSION, BE ATTACHED WITH THE APPLICATION.
- b) COPY OF PASSPORT DULY SELF ATTESTED.
- c) COPIES OF ALL MEDICAL DEGREE/DIPLOMA DULY SELF VERIFIED. IN CASE, THE DOCUMENTS ARE IN LANGUAGE OTHER ENGLISH THEN TRUE COPY OF THE DOCUMENT(S) ALONGWITH AUTHENTICATED COPY OF THE SAME IN ENGLISH VERSION, BE ATTACHED WITH THE APPLICATION.
- d) SELECTION/ACCEPTANCE LETTER FROM THE INSTITUTE/HOSPITAL CONCERNED IN INDIA.
- e) NON REFUNDABLE APPLICATION FEE OF RS. 5000/- (RUPEES FIVE THOUSAND ONLY) + 18% GST BY A BANK DRAFT IN FAVOUR OF "THE SECRETARY, MEDICAL COUNCIL OF INDIA", PAYABLE AT NEW DELHI. ON REVERSE OF THE DRAFT, FOLLOWING DETAILS TO BE FILLED BY THE APPLICANT AND DULY SIGNED: -
 - (i) Name
 - (ii) Father's Name
 - (iii) Purpose for which the draft submitted
 - (iv) Telephone No with Code/Mobile No.

2 **APPLICATION FOR TEMPORARY REGISTRATION FOR POSTGRADUATE TRAINING/COURSE/FELLOWSHIP MUST BE RECEIVED THROUGH THE HEAD OF THE HOSPITAL/INSTITUTE IN INDIA ALONGWITH ALL DOCUMENTS AS MENTIONED ABOVE. NO DIRECT APPLICATION FROM THE FOREIGN NATIONALS WILL BE ENTERTAIED.**

APPLICATION MUST BE RECEIVED IN THE COUNCIL OFFICE AT LEAST 2 MONTHS IN ADVANCE FROM THE SCHEDULED STARTING DATE OF POSTGRADUATE TRAINING/COURSE/FELLOWSHIP.

3. APPLICANT IS ADVISED TO RETAIN COPY OF HIS/HER APPLICATION AND DRAFT FOR FUTURE REFERENCE.


CHECK LIST for submission of documents

THE CANDIDATES ARE REQUESTED TO ENSURE THAT THE DOCUMENTS BE ENCLOSED AS PER THE ORDER IN THE CHECKLIST. ALL PAPERS/DOCUMENTS SHOULD BE NUMBERED ACCORDING TO THE CHECKLIST. PLEASE ARRANGE THE APPLICATION IN THE FOLLOWING ORDER & TICK MARK THE RELEVANT BOXES:

- | | | | |
|----|--|------------------------------|-----------------------------|
| 1. | Bank Draft: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Application form (Two sets)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Copies of degree or diploma or certificate (Two sets) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Certificate of permanent Registration (Two sets) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Sponsorship/Appointment/Acceptance letter from the Hospital/Institution concerned in India (Two sets)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Copy of passport (Two sets)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. | Admission letter from the college/hospital where the training is to be scheduled..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Signature _____

Dated _____

	<h1>MEDICAL COUNCIL OF INDIA</h1> <p>Pocket - 14, Sector - 8, Phase-I, Dwarka, New Delhi - 110 077 Phone : 011-25367033,25367035, 25367036, Email : mci@bol.net.in, Website : http://www.mciindia.org</p>
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ACKNOWLEDGEMENT

(to be filled by the candidate)

Received Application from Ms/ Mr..... D/o / S/o
Sh..... alongwith Bank Draft/DD No.....
dated..... for Rs..... Drawn on
Bank..... for issuance of Temporary
Registration/Permission.



Signature of Receiving Official
with date