ACT. SECTION. 21, 30
BY-LAW. SECTION.6

FORM.3

MEDICAL BOARD OF PAPUA NEW GUINEA
MEDICAL REGISTRATION ACT 1980

APPLICATION FOR TEMPORARY REGISTRATION AS A:

MEDICAL PRACTITIONER
~~DENTAL PRACTITIONER (DENTIST)~~
~~ALLIED HEALTH WORKER~~

I/~~We,~~ ENTER NAME _____

Director/Governing body of **MEMBER OF** _____

Institution **DOCTORS ASSISTING IN SOUTH-PACIFIC ISLANDS (DAISI)** _____

hereby apply on behalf of **MYSELF** _____

of ENTER ADDRESS _____

for a certificate of temporary registration as a

MEDICAL PRACTITIONER
~~DENTAL PRACTITIONER (DENTIST)~~
~~ALLIED HEALTH WORKER~~

The qualifications of the said ENTER NAME _____

is ENTER QUALIFICATIONS _____

The probable duration of required temporary registration

Is ENTER DATES _____

Dated this _____ day of _____ 20 .

.....
Signature of Applicant

Before me: _____
Commissioner for Oaths

**Strike out whichever is inapplicable.*

Email to: pouharo@gmail.com pou_haro@health.gov.pg florie_kapueina@health.gov.pg

Registration No:

Practitioner No:

Independent State of Papua New Guinea

HEALTH CARE PRACTITIONERS – LICENSURE & REGISTRATION

MEDICAL REGISTRATION ACT – 1980 & MEDICINES AND COSMETICS ACT – 1999

NOTE: Before filling the form, read the Instructions at the back and enter all information required – 10Q.

PERSONAL DETAILS

TITLE; MISS MS MRS DR OTHERS		
LAST NAME:	*FIRST NAME:*	*DATE OF BIRTH: ...../...../.....*
MARITAL STATUS;	*NATIONALITY:*	*GENDER:*
	HOME PROVINCE:	*NAME OF VILLAGE:*
ADDRESS:	*HOME PHONE:*	*BUSINESS PHONE:*
	EMAIL ADDRESS:	

APPLICATION DETAILS

APPLICATION FOR:

☐ NEW REGISTRATION FOR CERTIFICATE TO PRACTICE	☐ ANNUAL RENEWAL OF CERTIFICATE TO PRACTICE	☒ TEMPORARY CERTIFICATE
☐ PROVISIONAL CERTIFICATE	☐ RESTORATION OF CERTIFICATE	☒ FEES WAIVER
		☐ PROBATIONAL CERTIFICATE

AS: MEDICAL BOARD

☒ MBBS	☐ DENTAL THERAPIST	☐ BIO-SCIENTIST
☐ HEO	☐ DENTAL TECHNICIAN/MECHANICIANS	☐ PSYCHOLOGIST
☐ ANAESTHESTICS/ATO	☐ BDS (DENTAL PRACTITIONER)	☐ OPTOMETRIST/OPHTHALMIC CLINICIAN (EYE CARE)
☐ MLT/MLA (MT)	☒ SPECIALIST (MP/DP/AHW)	☐ OPTICIANS – (EYE GLASS)
☐ RADIOGRAPHER (MIT)	☐ EHO	☐ RADIATION THERAPIST
☐ CHW	☐ PHYSIOTHERAPIST	☐ AUDIOLOGIST (TESTING AND HEARING)
☐ OCCUPATIONAL HEALTH & SAFETY THERAPIST	☐ NUTRITIONIST/DIETITIAN	☐ PARAMEDIC
☐ DENTAL HYGIENIST	☐ SPEECH AUDIOLOGIST (SLOW LEARNER)	☐ PROSTHETIST & ORTHOTIST
☐ CHIROPRACTICE TECHNOLOGIST	☐ AUDIOLOGIST OR HEARING	☐ DENTAL NURSE
		☐ SOCIAL WORKERS

INITIAL TRAINING & REGISTRATION DETAILS

HEALTH CARE PRACTITIONER QUALIFICATIONS:	*INITIAL REGISTRATION DATE: (M/BOARD TO FILL THIS SPACE)*
INSTITUTION:	*COUNTRY:*
DATE STARTED: ...../...../.....	*DATE COMPLETED: ...../...../.....*
PROGRAM TITLE:	*DATE SIGHTED (M/BOARD TO FILL THIS SPACE)*

EMPLOYMENT DETAILS

HEALTH CARE WORKER TYPE (CADRES) SPECIALIST DOCTOR	*FUNCTION TYPE* VOLUNTEER	*PLACE OF WORK:* SOPAS DISTRICT
AREA OF EMPLOYMENT: . GOVERNMENT . CHURCH . PRIVATE (NGOs) . UNEMPLOYMENT . OTHERS (SPECIFY)	DAISI (Doctors Assisting In South Pacific Islands)	
STATUS OF EMPLOYMENT: . FULL TIME (PART TIME) .STUDYING .UNEMPLOYED	I AM A VOLUNTEER FOR DAISI & AM APPLYING TO VOLUNTEER AT SOPAS DISTRICT HOSPITAL ON THE INVITE OF DR JAPHLET	
REASONS FOR UNEMPLOYMENT:		
NAME OF EMPLOYER: DAISI	*EMAIL NO:* staff@daisi.com.au	*PHONE NO:* +61 478 067 159

POST-GRADUATE QUALIFICATION (S)

QUALIFICATION TYPE: 1 ..... *2 .....* *3 .....*	*PROGRAM TITLE: 1 .....* *2. .....* *3. .....*
DATE STARTED: 1. ...../...../...../ 2. ...../...../...../ 3. ...../...../.....	*DATE COMPLETED: 1. ...../...../..... 2. ...../...../...../ 3. ...../...../.....*
INSTITUTION: 1. ..... *2. .....* *3. .....*	*COUNTRY: 1. .....* *2. .....* *3. .....*

SIGNATURE: _____ DATE: _____/_____/_____

MEDICAL BOARD OF PAPUA NEW GUINEA

FOR OFFICE USE ONLY **OFFICIAL RECEIPT:**	**AMOUNT K**	**DATE: ...../...../.....**