ACT.SECTION.21, 30

BY-LAW , SECTION .6

FORM.3

MEDICAL BOARD OF PAPUA NEW GUINEA
MEDICAL REGISTRATION ACT 1980

APPLICATION FOR TEMPORARY RESGISTRATION AS A:

*Tick whichever is applicable

- [x] MEDICAL PRACTIONER
- [ ] DENTAL PRACTITIONER
- [ ] ALLIED HEALTH WORKER

I ______________________________

Director /Governing body of MEMBER AND VOLUNTEER FOR

Institution DOCTORS ASSISTING IN SOUTH-PACIFIC ISLANDS (DAISI)

hereby apply on behalf of MYSELF

for a certificate of temporary registration as a

*Tick whichever is applicable

- [x] MEDICAL PRACTIONER
- [ ] DENTAL PRACTITIONER
- [ ] ALLIED HEALTH WORKER

The qualifications of the said ______________________________

is ______________________________

The probable duration of required temporary registration

is ______________________________

Dated this ____________ day of ____________ 20 ____________

____
signature of applicant

Before me ______________________________
Commisioner of Oaths / Justice of the Peace

*Strike out whichever is inapplicable

Registration No:

Practitioner No:

Independent State of Papua New Guines

HEALTH CARE PRACTITIONERS - LICENSURE & REGISTRATION

MEDICAL REGISTRATION ACT - 1980 & MEDICINES COSMETICS ACT - 1999

NOTE: Before filling the form, read the instruction 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:

ADDRESS: HOME PROVINCE NAME OF VILLAGE

HOME PHONE: BUSINESS PHONE:

EMAIL ADDRESS:

APPLICATION DETAILS

APPLICATION FOR

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

AS: MEDICAL BOARD

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

INITIAL TRAINING & REGISTRATION DETIALS

HEALTH CARE PRACTIONER 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) FUNCTION TYPE PLACE OF WORK WORK

AREA OF EMPLOYMENT: ☐ GOVERNMENT ☐ CHURCH ☐ PRIVATE ☐ NGO ☐ UNEMPLOYMENT ☐ OTHER

STATUS OF EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ STUDYING ☐ UNEMPLOYED

REASON FOR UNEMPLOYMENT

NAME OF EMPLOYER EMAIL: Phone:

POST-GRADUATE QUALIFICATION (S)

QUALIFICATION : 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: