6. Name in full (surname, with the full significance of the initials)

7. Father's Name … … …

8. Original qualifications … … …

9. Name of the Medical Council and the
Number and date of registration certificate …

10. Additional qualifications in respect of which
registration is sought.

Date: Signature of the candidate

(To be filled in by the office only)

1. Fee for additional qualifications **...** **...** _____

2. Date of payment **...** **...** **...** _____

3. Date of production of the evidence of qualifications _____

4. Date of registration of additional qualifications _____

Remarks if any
(By the Registrar only)