



REPUBLIC OF KENYA
THE MEDICAL PRACTITIONERS AND DENTISTS ACTS
(NO.20 of 1977)
APPLICATION FOR PRE-REGISTRATION EXAMINATION

1. SurnameOther Names
2. Date of Birth.....Nationality.....I.D/Passport Number.....
3. Address.....Code.....Town.....Tel.....
4. Email.....
5. Degree, Diploma or Licence held (*give name of medical school and date qualified – if degree not in English, provide official translation*)
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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 professional certificates
- (iv) Evidence of appropriate linguistic skills in English and/or Kiswahili for non-Kenyans
- (v) Academic transcripts or Evidence of internship
- (vi) Curriculum Vitae
- (vii) Evidence of completion of internship or Registration from a Medical Council
- (viii) Must be attached at a Ministry of Health approved internship centre for a period of 4 months
- (ix) Letter from Commissioner for Higher Education (CHE) confirming recognition of the medical/dental school (if foreign trained)
- (x) Qualification; Form IV or VI certificate
- (xi) Application fee Kshs.5,000.00
- (xii) Examination/ Evaluation of qualification papers - Fees Kshs.50,000.00
- (xiii) **All payments should be made at any KCB Branch countrywide to Board's account No. 1103158643, Milimani Branch.**

Signature of applicant Date.....

<p>PREPARED BY: -</p> <p>Name:.....Designation.....</p> <p>Signature.....Date.....</p> <p>CHECKED BY: -</p> <p>Name:.....Designation.....</p> <p>Signature.....Date.....</p>	<p>APPROVED/NOT APPROVED</p> <p>Name.....</p> <p>Designation.....</p> <p>Signature.....</p> <p>Date.....</p>
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