REPUBLIC OF KENYA

MEDICAL PRACTITIONERS AND DENTISTS BOARD

APPLICATION FOR ACCREDITATION AS A CPD PROVIDER

PLEASE READ THIS SECTION CAREFULLY BEFORE COMPLETING THE FORM

- The application form must be completed by a duly authorized person
- Every application must be accompanied by:-
    - The application fee of **Ksh.15, 000 (non-refundable).**
    - Calendar of activities
    - Names of two referees.

* ***All payments should be made at any KCB Branch countrywide to Board's account No. 1103158643, Milimani Branch.***

PART A: ADMINISTRATIVE INFORMATION

1. Particulars of Applicant	
a) Name of institution:	
b) Permanent Address:	
c) Physical Address:	
d) City/Town:	e) County:
f) Postal Address:	g) Postal Code:
h) Plot No.:	i) LR No.:
j) Telephone No:	k) Mobile No.:
l) Email:	m) Website:
n) Fax:	
2. Name of Contact Person:	
Landline No.:	Mobile No.:
Email:	
Any other additional information:	

PART B: DECLARATION BY APPLICANT

I, the undersigned confirm that all the information in this form and accompanying documentation is corre ct and true to the best of my knowledge. I further agree to inform the MPDB, about any changes or modif ications made to the information given in the document submitted.

Name of Head of Institution/Department: _____

Signature: _____

Name of CPD coordinator: _____

Signature: _____

Date of Application: _____

Official Stamp:

PART C: FOR MPDB OFFICIAL USE ONLY

PREPARED BY: - Name:……..Designation…… Signature…… Date…… **CHECKED BY: -** Name:…….Designation……. Signature…….. Date…….....	**APPROVED/NOT APPROVED** Name…… Designation…….. Signature……Date……...