



REPUBLIC OF KENYA

**THE MEDICAL PRACTITIONERS AND DENTISTS ACTS
(CAP 253)**

FORM II

APPLICATION FOR PERMANENT REGISTRATION AS A MEDICAL OR DENTAL PRACTITIONER

1. SurnameFirst Name.....Other Names.....
2. Date of Birth.....Nationality.....
3. ID No./Passport No.....
4. Address.....Code.....Town.....County.....Cell Phone.....
5. Email.....
6. Degree, Diploma or Licence held.....Dates qualified.....
7. Name of medical/dental school.....Email.....
8. Name of Internship Training Centre.....Email.....
Period of internship from.....to.....
9. Particulars and testimonials covering the period(s) of experience.....
10. Name of employer.....
 Address.....Code.....Town.....County.....
 Email.....Tel.....

Requirements

- a) **Internship Completion Certificate downloadable from www.medicalboard.co.ke**
- b) *Copy of ID/Passport*
- c) *Coloured passport size photo*
- d) *Certified copies of professional & academic certificates*
- e) *Evidence of passing Board's pre-registration examination (foreign trained)*
- f) *Dully filled, stamped and signed Internship completion Assessment Forms.*
- g) *Evidence of registration from EAC Partner States Board's and councils (for those applying for reciprocal registration)*
- h) *Registration Fee Kshs.8,000*

All payments should be made at any KCB Branch countrywide to Board's account No. 1103158643, Milimani Branch. SWIFT CODE: KCBLKENX, BANK: KCB, BANK CODE: 01175

I hereby certify that the above information is correct to the best of my knowledge and that I have met the above requirements.

Signature of Applicant:.....Date

FOR OFFICIAL USE

The process will take a maximum of two weeks.

PREPARED:	APPROVED/NOT APPROVED
Name:.....Designation.....	Name.....
Signature.....Date.....	Designation.....
RECOMMENDED:	
Name:.....Designation.....	Signature.....
Signature.....Date.....	Date.....