Application Form for Registration with the Medical Council of Malta

Personal details

Family Name or Surname	
First Name	
Nationality/Nationalities	
Date of Birth	
Age	
ID No. / Passport No.	
Gender	
Full address	
Country	
Post Code	
Status within EU	
Telephone/Mobile numbers	
e-mail address	

The Medical Council reserves all rights to take remedial action and legal procedures in case of failure of disclosure and/or false declarations provided by the applicant.

Registration Type requested: *(please note that the eligibility of the type of registration you can hold is the Council's prerogative)*

I am applying for the following type(s) of registration with the Medical Council of Malta	Tick (√)
a) Provisional registration	

Checklist:

1. A certified true copy of the original Passport or Identity Card.[(i)]
2. A certified true copy of the original Birth Certificate.[(i)]
3. A certified true copy of the original Primary Medical/Dental Qualification.[(i)]
4. A detailed Transcript of the Basic Medical/Dental Qualification. [(i) (ii)]
5. An original Certificate of Compliance from the competent authority.[(iii)]
6. An original Police Conduct/Certificate of Good Standing from competent authority (this is valid for 3 months from the date of issue).
7. A detailed Curriculum Vitae (CV) in English Version.[(iv)]
8. Original official translations of any documents/certificates as per above, that are not in English or Maltese.

[(i)] *A 'Certified True Copy' of this document is required. This is to be authenticated by a Notary, or a Lawyer, or by a Maltese Embassy, or a High Commission in your country; and this needs to be Apostilled. Alternatively, the original document and a copy need to be personally provided for verification.*
[(ii)] *Required by applicants graduating from non-EU Institutions or from EU Institutions prior to EU Accession.*
[(iii)] *Required for doctors and dentists graduating before 1st May 2004 from Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia; and for doctors and dentists graduating before 1st January 2007 from Bulgaria and Romania.*
applicants who completed their internship since 2010 are to submit the FACD.
[(iv)] *Optional*

Primary Medical/Dental qualification and training

Full title of your primary medical/dental qualification (including licence to practise if applicable)	
Abbreviation of qualification	
Name of the medical/dental school/university/body that awarded you qualification/licence and the country in which it is located	
Date awarded	

List below where you undertook the training leading to the award of your primary medical qualification and, if appropriate, your licence to practise.

Name of the medical/dental school/awarding body and the country in which it is located	Start date	Finish date

Declaration of Registration/s with any other Health Care Profession

Profession	Start date	Finish date
Academic Qualification		
University, institution or any other awarding body		
Registering institution/s		
Country and date of first registration		
Current registration/s		

Note: if applicable Certificates of Registration other than that of Medical Practitioner to be produced.

Registration Status *(optional)*

I declare that I am also registered in

Country and Competent Body	Date or Registration	Registration type	Status

OR

I declare that in the past I held registration in

Country and Competent Body	Date or Registration	Registration type	Status

And I am ready to submit further information if requested by the Medical Council

Yes: _____ No: _____

OR

I do not presently hold and never held registration with any other competent authority

_____

Postgraduate professional experience

Please list below where you have been working since qualifying, if applicable.

Post held and name and address of the employer	Country	Start date	Finish date

To be filled by ALL applicants

- Please indicate when you intend to take up work in Malta if applicable:

Day:	Month:	Year:

I confirm that the information I have provided in this application for registration is complete, correct and true. I understand that the Medical Council of Malta may make any enquiries that it deems appropriate of the medical/dental regulatory authorities or employers in the country in which I qualified or in any other country where I have worked. I understand that any false declaration in any part of this application or failure of disclosure or false information or documentation provided in support of this application may result in the Medical Council of Malta withholding or removing registration. I agree that all the information provided in this application form may be passed on to other regulatory bodies and relevant institutions.

Signature _____ Date _____

Please note:

1. ***This declaration must not be more than three (3) months old at the time your registration is granted. If for any reason your application is not processed within this time you may be asked to sign another declaration.***

2. ***The Medical Council will only be able to assist you upon the receipt of a duly filled application form and submission of documentation requested in the checklist.***

The complete Application form and Documents requested (as per checklist) are to be returned to:

The Registrar,
Medical Council Malta,
SLH-OPD, Level 1, St. Luke's Square, Gwardamangia, PTA 1010 Malta.

Data Protection Statement: All Data collected is processed in accordance with legal provisions, the Data Protection Act (Cap. 586) and the EU Regulation 2016/679 General Data Protection Regulation. Personal Data is not disclosed to third parties if not required by Maltese Law or by other EU obligations.