



Maldives Medical and Dental Council

Application for Registration and Practising License

It is an offence to practice medicine or dentistry in the Maldives without registration and obtaining a practising license from the Maldives Medical and Dental Council under the Health care Profession Act Law no. (13/2015) All medical officers (MBBS or equivalent) have to appear and clear the licensing exam conducted by MMDC to practice in Maldives.

- Notice:**
- 1- Please use **BLOCK** letters in filling this application form
Applicant must ensure the truth and accuracy of all information provided. Making a false declaration (including failure to disclose relevant information) is an offence punishable with imprisonment under the Health care Profession Act
 - 2- Items **I** to **V** are to be completed by the applicant.
 - 3- Item **VI** is to be filled, completed and endorsed by the current employer.
 - 4- Originals and a copy of each certificate, passport/ID and 5 passport size photo (only for registration) must be submitted along with this application. All originals will be returned after verification.
 - 5- Fees: Non-refundable
Pre registration: MVR 500
Provisional registration: MVR 300
Temporary basic registration: MVR 500
Permanent basic registration: MVR 750
Temporary additional (Specialist) registration: MVR 1000
Permanent additional (Specialist) registration: MVR 1500
Licensing: MVR 500
Reissuing for loss or damage: MVR 1000

Registration

New

Reissue for Loss / Damage

Extension

License

New

Reissue for Loss / Damage

Renewal

Serial No:

Receipt No:

Pre Registration

I PERSONAL DETAILS

Name: Sex: M F

Date of Birth: ID Card / Passport No:

Work Permit No:

Nationality: Contact No:

Permanent Address:

Current Address:
(If different from above)

E- Mail Address: Marital Status:

recent passport size
photograph
here

II REGISTRATION DETAILS

Registration Number:

Council / Authority of Registration:

Address:

Registered date: Expiry date:

III QUALIFICATIONS

Professional Qualification	Institute	City / Country	Duration
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

IV WORK EXPERIENCE

Organization	City	Country	Position held	Duration
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

V ATTESTATION QUESTIONS

Please answer all questions by selecting Yes or No and provide an explanation when requested.

For questions 1-2, the terms “impaired” and “limited” include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or abuse. The purpose and intended use of this information is to enable the Council to determine whether you meet statutory and rule requirements for licensure. The information provided remains confidential with the council. If additional space is necessary please attach a separate sheet.

1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? YES NO

1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment or participate in a monitoring program? If yes Please describe.

1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.

2. Are you engaged in any illegal use of controlled substances including the use of illegal substances or illegal use of legal controlled substances, If Yes Please describe.

YES NO

3. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety?

YES NO

3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? YES NO

If "yes", please answer the following:

4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

YES NO

4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

YES NO

4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

YES NO

4d. Identify your treating physician _____

5. Have you ever been denied a license by any medical council or licensing authority? If, yes give particulars

YES NO

6. Has your license to practice medicine been revoked, suspended, restricted, or conditioned by a Medical council or other licensing authority? If so, give particulars

YES NO

7. Have you ever been notified of any investigation by any medical council, or any hospital of any complaints against you relative to the practice of medicine? If so, give particulars

YES NO

8. Have you ever been a defendant in any malpractice lawsuit, had any malpractice settlement, or have any pending? If yes, give details

YES NO

9. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery or domestic abuse

YES NO

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in Maldives

Signature:

Date : day/month/year

VI PROPOSED/CURRENT EMPLOYMENT

Place of Proposed/Current Employment in Maldives:

Address:

Staff No:

Position :

Date of Employment:

day/month/year

Contract valid till:
(for contract staff only)

day/month/year

Tel No :

Declaration by Employer

We confirm the authenticity of the information contained herein about this organization and the applicant's employment status with us.

Name:

Signature:

Official Stamp

Date : day/month/year

DOCUMENTS TO BE SUBMITTED

- | | | | |
|-----------------------------------|--------------------------|--------------------------------|--------------------------|
| 1. Qualification Certificates | <input type="checkbox"/> | 6. Experience Certificates | <input type="checkbox"/> |
| 2. Internship Certificate | <input type="checkbox"/> | 7. English Language Competency | <input type="checkbox"/> |
| 3. Basic Registration Certificate | <input type="checkbox"/> | 8. Passport Copy | <input type="checkbox"/> |
| 4. Specialist Registration | <input type="checkbox"/> | 9. Visa Copy | <input type="checkbox"/> |
| 5. Good Standing Certificate | <input type="checkbox"/> | | |

Instructions to Applicants

1. Copies of the following original documents are to be sent to Maldives Medical and Dental Council (MMDC) in support of application.
 - a. National Identity Card or Passport.
 - b. Undergraduate and postgraduate medical qualifications as applicable.
 - c. Documentary evidence of internship, not less than 52 weeks.
 - d. Certificate of Good Standing (CGS) issued by the medical licensing authority of the country where the doctor has been practicing for the last 01 year prior to the application. The CGS received by MMDC must not exceed 03 months from its issued date.
 - e. Certificates of registration with other medical licensing authority.

2. All foreign applicants are required to submit evidence of competency in English Language to the MMDC.

Test results obtained from the International English Language Testing System (IELTS) test OR the Test of English as a Foreign Language (TOEFL) within the minimum score stated here can be considered, subject to a validity period of 02 years based on the date of the test.

IELTS - at least 6 for overall score

TOEFL - 250 marks for computer-based test or 600 marks for paper-based test or 100 marks for internet-based test.

3. In addition to above, applicants for temporary registration as visiting experts need to submit an original letter from sponsoring institution registered in the Maldives stating the purpose of the visit and period.

4. Additional notes:

- a. Documents in foreign language shall be submitted together with the certified English translations and original copies of the documents. The Maldives Medical and Dental Council will accept translation by (i) the institute that issued the original certificate, (ii) any embassy or consulate of the country that issued the original certificate, (iii) relevant regulatory body of the country that issued the original certificate.
- b. All documentation submitted should be complete and legible. The council will not process illegible, unclear or incomplete copies. Maldives Medical and Dental Council will not be responsible for delays that occur due to submission of illegible or incomplete documentation.
- c. The MMDC may also require the doctor to submit any other documents for evaluation of his/her application.

5. All supporting documentation must be submitted through the employer to the following address:

Secretariat
Maldives Medical and Dental Council
Ministry of Health
Roashanee Building
Sosun Magu
Male', Maldives