

Medical and Dental Council of Nigerian

CPD Accreditors' Form

1. INSTITUTION APPLYING TO BE RECOGNIZED AS AN ACRREDITOR

Name

Address.....

.....

.....

Telephone No. Fax

E-Mail..... Website

Nature of Organization

.....

.....

Area/s of Experience (Tick as Applicable)

- Basic Medical Sciences
- Clinical Medical/Dental Subspecialties
- Administration/Management
- Information and Communication Technology
- Law/Medico-Legal
- E- Learning
- Others (Specify).....

2. PARTICULARS OF PERSON/S RESPONSIBLE FOR ACCREDITATION ON

BEHALF OF THE ORGANIZATION

- 2.1 Name
- 2.2 Qualifications (with date)
.....
- 2.3 Designation
- 2.4 Phone Nos.....(office).....(Mobile).....
- 2.5 E- mail
- 2.6 Area/s of Specialization/Experience.....
.....
.....
.....
- 2.7 Publications
.....
.....
.....
- 2.8 Attach Curriculum Vitae and use extra sheets where necessary

2. ATTESTATION

Ion behalf of
(Name of Head of Institution)

.....affirm that the
(Name of Institution)

information above are true and we undertake to comply with the requirements of serving as CPD accreditor.

.....
Signature of Head of Institution

.....
Date

FOR OFFICE USE ONLY

Having fulfilled the necessary requirements

.....has been approved/
(Name of Institution Applying)

not approved as a accreditor for.....
(Type of CPD Activity)

.....
Registrar
Medical and Dental Council of Nigeria

.....
Date

***Enquires about CPD could be made from cpd@mdcnigeria.org**

MEDICAL AND DENTAL COUNCIL OF NIGERIA

CPD PROVIDERS' FORM



1. Name of Institution/Organization
.....
2. Office Address.....
.....
3. Telephone No
4. E –Mail..... Website.....
5. Category of Organization
 Government
 NGO
 Private
6. Registration with Corporate Affairs Commission (Where Applicable)
 Limited Liability
 Plc
 Enterprise/Business Name
7. List of Directors
.....
.....
.....

STAFF LIST/ADMINISTRATIVE SUPPORT

(Attach Separate Sheet)

8. Type of Accreditation Requested

- Basic Medical Sciences
- Medical/Dental Subspecialty
- Administration/Management
- Information and Communication Technology
- Law/Medico -Legal
- E-learning
- Others

9. Experience/Evidence of previous Performance(if any)

.....
.....
.....
.....
.....
.....

10. List of Prospective Persons to Deliver **CPD**, Qualifications and evidence of Expertise (attach separate sheets, including photocopies of credentials) originals will be sighted.
All medical doctors involved must show evidence of current Practicing Licence.

11. Accreditation fees paid (attach photocopy of receipt)

.....

.....
Full Names and Signature of CEO

.....
Date

FOR OFFICE USE ONLY

I certify that..... has
(Name of Institution)

Fulfilled/not fulfilled the requirements of necessary for the purpose of
serving as a **CPD** Provider in the area of

.....
(Type of Activity)

.....
Name and Signature Accreditor

.....
Date

..... is hereby
(Name of Institution)

Accredited /not accredited as a **CPD** Provider in the area of

.....
(Type of Activity)

.....
Registrar
Medical and Dental Council of Nigerian

.....
Date

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Medical and Dental Council of Nigeria

CPD PARTICIPANTS' FORM

MDCN REG. NO..... Folio No.....

SURNAME.....

OTHER NAMES.....

BASIC QUALIFICATION/YEAR OF GRADUATION.....

ADDITIONAL QUALIFICATION.....

NO OF YEARS OF PRACTICE.....

PLACE OF WORK.....

PRESENT APPOINTMENT/DESIGNATION.....

TYPE OF CPD ACTIVITY.....

CREDITS/NO. OF HOURS

