MEDICAL AND DENTAL COUNCIL OF NIGERIA

OF

NIGERIA

FORM B - 1

FORM FOR APPLICATION

FOR

FULL REGISTRATION

AS A PRACTITIONER OF

ALTERNATIVE MEDICINE

MEDICAL AND DENTAL COUNCIL OF NIGERIA

A Parastatals of the Federal Ministry of Health Established by Cap M8, Laws of the Federation 2008
HEAD OFFICE: Plot 1102, Cadastral Zone B11, Off Oladipo Diya Road, Behind Prince and Princess Estate, Kaura District, P.M.B 458, Garki, Abuja, Federal Capital Territory .Website: www.mdcnigeria.org.
09-2902900, 2901435, 7803357, 2901349, e-mail: info@mdcnigeria.org,

APPLICATION FOR FULL REGISTRATION AS PRACTITIONER OF ALTERNATIVE MEDICINE

PROVISIONAL REGISTRATION NO:..... FOLIO NO:.....

I hereby apply for *FULL REGISTRATION* as a Practitioner of Alternative Medicine in accordance with the following particulars:

1. **Full Names of Applicant (No abbreviations please):**
   (a) SURNAME:_____
   (b) OTHER NAMES:_____
   (c) PREVIOUS NAMES (if any):_____
2. (a) Sex:_____ (b) Marital Status:_____
3. (a) Date of Birth:_____ (b) Place of Birth:_____
   (c) Email address: _____ (d) Tel No: _____
4. **Nationality Data**
   (a) Home Town:_____
   (b) Local Government Area:_____
   (c) State of Origin:_____
5. **Full Residential Address in State of Origin**:_____
   _____
6. **Full Business Address:**_____
   _____
7. **Postal/Contact Address (**if different from 5 & 6): _____
   _____
8. **Educational Data**
   (a) SCHOOLS ATTENDED (Give full name and address)

		Dates attended	
	Name of Institution	**From**	**To**
Primary:			
Secondary:			
Tertiary:			

(b) **PROFESSIONAL ACADEMIC QUALIFICATIONS OBTAINED WITH DATES**

Qualification	Date	Licensing Body

9. **Post Professional Experience including details**

Full Name of Hospital	Address	Period of Employment	
		From	To

10. **Present Appointment:**

Hospital or Institution	Address	Position Held	Date of Appointment

11. Have you ever faced the Medical & Dental Practitioners' Disciplinary Tribunal in Nigeria or any other country? If 'yes', give full details (*use additional paper if necessary)*

☐ Yes ☐ No

Details: _____

_____

_____

_____

12. Give the Names of Three (3) Referees (not relatives) one of whom must be a rcognized senior practitioner in your profession

Name of Referee	Full Address	Occupation & Status
1.		
2.		
3.		

SUPPORTING DOCUMENTS

Attached/enclosed are relevant evidence of all my academic and professional qualifications, my birth certificate, the certified cheque for the registration fee and two recent passport photographs of me, the applicant

_____
Signature of Applicant

_____
Date

Note: Payment of the registration fee must be by BANK CERTIFIED CHEQUES payable to "MEDICAL & DENTAL COUNCIL ON NIGERIA'. And completed application forms should be returned to the REGISTRAR, MEDICAL & DENTAL COUNCIL OF NIGERIA at any of the following offices:

Lagos Zonal Office
No 25, Ahmed Onibudu Street
Victoria Island
P. M. B. 01431
Pmb 12611.
Lagos
Tel: 01-8979432,
8979301, 8979130

Enugu Zonal Office
2 Ogufere Street
Off Okpara Avenue
Enugu.

Kaduna Zonal Office
6 North Road,
Via Abakpa N.E.P.A.
Sub-Station (Red Cross Compound)
P. M. B. 2275, Kaduna.

All practitioners wishing to become registered as practitioners of Alternative Medicine in Nigeria MUST give satisfactory evidence of having received appropriate training in a recognized Alternative Medicine Training Institution.

All practitioners seeking registration from Council must also pay their licensing fees.

NOTE WELL: Payment of fees BY CASH to or through ANY STAFF of Council is a punishable contravention of Council regulations. You must not do so under any circumstance.

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FORM G - 2

FORM FOR APPLICATION FOR LICENCE TO PRACTISE ALTERNATIVE MEDICINE IN NIGERIA

NOTE: All items of information requested in this form are REQUIRED to be fully and correctly supplied.

I hereby apply for licence to practise Alternative Medicine in Nigeria for the year(s): - _____

FOLIO NO: MDCN/ALT/R/

My particulars are as follows:-

1. Full Names (In Capital Letters; No Abbreviation):
   _____
   Surname First Name Middle Name
2. Previous Names (if married, indicate maiden name and attach evidence of change of name)
   _____
3. Date of Birth: _____ (4) Place of Birth: _____
5. Nationality: _____ (6) Sex: Male > ☐ Female > ☐
7. Marital Status: Single > ☐ Married > ☐ Widowed > ☐ Divorced > ☐
8. Home Town: _____ 9. State of Origin: _____
10. (a) Residential Address: _____ __
    _____
    (b) Business Address: _____
    _____
    (c) Permanent Address in State of Origin: _____
    _____
    (d) Email:_____ (e) Tel No: _____
11. Location of Practice:
    (a) State: _____
    (b) Local Government Area: _____

(c) Town: _____

12. Qualifications with dates:
    (a) Basic: _____

    (b) Additional: _____

13. Institutions where Qualifications were obtained:
    (a) Basic:_____

    (b) Additional: _____

14. Registration Number and Date of Registration:

    PROVISIONAL REG. NO: PA_____ DATE:_____

    FULL REG. NO: FA_____ DATE:_____

    ADDITIONAL REG. NO: AQA_____ DATE:_____

    TEMPORARY REG. NO: TA_____ DATE:_____

15. Date of expiration of current Registration (for Doctors with Provisional or Temporary Registration) _____

16. Date or expiration of current Licence _____

17. Specialty: _____

18. Present appointment (indicating date of commencement and present status or position and the institution): _____
    _____

19. Nature of Place of Employment:

    ☐ Public Institution/Hospital ☐ Mission

    ☐ Private Establishment (Hospital, Company) ☐ Other

AMOUNT ENCLOSED

N : K

Cheque No: _____

_____

Signature of Doctor

_____

Date of Application

MEDICAL AND DENTAL COUNCIL OF NIGERIA

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FORM FOR APPLICATION FOR PROVISIONAL REGISTRATION AS AN ALTERNATIVE MEDICAL PRACTITIONER IN NIGERIA

NOTE : All items of information requested in this form are REQUIRED to be fully and correctly supplied. A failure to comply with this requirement invalidates the application.

I hereby apply for PROVISIONAL REGISTRATION as an Alternative Medical Practitioner in Nigeria in the area of :

Acupuncture ☐ Homeopathy ☐

Naturopathy ☐ Osteopathy ☐

Others (specify) ☐

My particulars are as follows :

1. Application's Full Names (in Capital Letters ; No Abbreviation) :

   _____ _____ _____

   Surname **First Name** **Middle Name**

2. Previous names (if any ; indicate maiden name and attach evidence of change of name, if married) :

   _____

3. Date of Birth: _____ (4) Place of Birth: _____

5. Nationality: _____ (6) Sex: Male ☐ Female ☐

7. Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

8. Home Town: _____ (9) State of Origin: _____

10. (a) Residential Address:_____

    _____

    (b) Business Address: _____

    _____

    (c) Permanent Address in State of Origin: _____

(d) Email:_____ (e) Tel No:_____

11. Educational Institutions attended (give full and verifiable address)

	Name of Institution	Date of attendance		Qualifications Obtained
		From	To	
PRIMARY				
SECONDARY				
TERTIARY				
Alternative Medical Training Institution				

12. Academic and Professional Qualifications Obtained with dates

Qualification	Date	Institution

13. Referees (indicate full names and contact addresses, which MUST NOT be your address. The referee must not be a blood relation of yours)

Referee	Academic Qualification	Status	Full Contact Address

14. Have you been previous registered by any Medical Council anywhere in the world?

Yes ☐ No ☐

(If 'yes', give details and attach evidence)

15. Have you had any recognized practising experience?

Yes No

(If 'yes', give details and attach evidence)

16. Have you been convicted by any court of Law?

Yes ☐ No ☐

(if 'yes', give details)

17. PLEDGE OF APECIFICITY

"I hereby pledge to confine myself to the practice of Alternative medicine in the management of human illness and never to engage in illegal orthodox medical practice".

18. AFFIRMATION

I hereby solemnly affirm that all information given above are true in all materials particular and contain nothing which would mislead the Medical and Dental Council of Nigeria into taking a wrong decision on my application. I also solemnly affirm the pledge which I have made in No. 17 above.

(Attached are relevant evidences of all academic and professional qualifications, my birth certificate, two recent passport photographs of me, the applicant and the certified cheque for the registration fee)

AMOUNT ELCOSED
N **K**
Cheque No _____

_____
Signature of Applicant

Date _____

Completed application forms are to be returned to:

The Registrar
Medical and Dental Council of Nigeria
Plot 1102, Cadastral Zone B11, Off Oladipo Diya Road,
Behind Prince and Princess Estate, Kaura District,
P.M.B 458, Garki, Abuja,