To be filled in Quadruplicate
use additional sheets if
required

PAKISTAN MEDICAL & DENTAL COUNCIL

APPENDIX-9

G-10/4, MAUVE AREA ISLAMABAD
TEL: 051-9106151-54 Fax No.051-9106159
Website: www.pmdc.org.pk E-mail: pmdc@pmdc.org.pk
These forms can be downloaded from our website by using Acrobat Reader. Photocopy of this form is also acceptable

The Registrar
Pakistan Medical & Dental Council
Islamabad.

Photograph is to be pasted here and then to be attested

PMDC-VI
APPLICATION FORM
FOR
RECOGNITION OF OVERSEAS POSTGRADUATE MEDICAL /DENTAL QUALIFICATION FOR
RECOGNITION ON INDIVIDUAL MERIT

(Please see instructions on page 5)

1. Name_____Sex_____

2. Father's/ Name_____

3. Registration No._____ Date _____Valid upto_____

(if your basic Medical qualification like M.B.B.S already registered with this Council and applying for Recognition of postgraduate qualification). Attach photocopy of registration certificate.

4. Nationality: _____

(i) Present:

(ii) Previous, if any (in case of foreign nationals, the purpose for which visa for entry into Pakistan was granted and the intended period of stay in Pakistan may please be stated).

5. Addresses Present

_____

_____

Permanent_____

_____

6. Purpose of recognition_____

7. POSTGRADUATE QUALIFICATION:

(i) Title of Postgraduate Qualification_____
(ii) Name of the Institution and examining body_____
(iii) Pre-entrance requirement (for example degree, House Job, Years of Residency etc.)_____
(iv) Duration of the Course/Pre-requisite Training _____
(v) Credit hours _____
(vi) Details of the subjects studied year-wise.

1st Year
2nd Year
3rd Year
4th Year
5th Year
6th Year

(vii) Details of examination passed year-wise:

Year of passing	Subject	Number of papers	MARKS Obtained/Total
1st Year			
2nd Year			
3rd Year			
4th Year			
5th Year			
6th Year			

(viii) Whether the qualification conferred/awarded after proper evaluation/examination? yes ☐ no ☐

If yes, the System of examination Whether Internal assessment ☐ Comprehensive Examination ☐ Both ☐

Full time ☐ distant learning ☐

Mark "X" in relevant Box

8. Proof of registration in the State or Country in which qualification was obtained conferring the applicant right to practice as consultant / specialist, if available.

9. Details of professional experience:

   a. Abroad

   b. In Pakistan

10. Present Occupation

It is certified that all information given above is correct to the best of my knowledge, if at any stage the information s submitted is found to be incorrect my registration/ recognition may be cancelled.

Name :_____ Signature of applicant_____

Tel:_____ Email:_____ Date_____

Date :_____

Phone :_____

FOR OFFICE USE

(I) The qualification of

_____

In respect of _____

Registration No_____ has been recognized

as equivalent to _____

(II) Recognition Committee meeting dated_____

held at_____

(III) Fee received vide receipt No. dated_____

(IV) Recommended for registration.

ASSISTANT REGISTRAR SUPERINTENDENT REGISTRAR

CONSENT TO RELEASE OF INFORMATION AND RELEASE OF LIABILITY IN RESPECT OF PM&DC AND THE INSTITUTION (Foreign Qualifications)

1. Name of Authorizing Physician and Email Address: _____

2.Identity of Institution or Person from whom information: is sought _____

3.***Said Qualification*** Name of Qualification (about which information is being sought) _____

Specialty: _____ Subspecialty: _____

4. ***(Provider) institution awarding the degree*** _____ with its relevant hierarchy, staff and Faculty who I am authorizing to release information concerning me and my qualifications.

5. ***Requester*** Identity of Institution or Person requesting information: "Pakistan Medical and Dental Council (PM&DC) or agents and authorized representatives/officials so designated in writing by or for it

PURPOSE: I am providing this request and consent in order to facilitate the process and verification of my qualifications from the above institution (provider) by the PM&DC (requester).

REQUEST: I specifically request that **(provider)**_____ provide to the requester or any representative designated in writing by the requester, any and all information, documents, and records concerning" my professional performance; competence, character during attainment of qualifications including syllabus etc, registration of the qualification information work experience and behavior while a resident and/or fellow, specifically including the circumstances of my departure from the institution. I further specifically request that **(provider)** _____ provide such information whether it came into possession of that information prior to my residency/fellowship, during my residency/fellowship, or after my residency/fellowship towards attainment of the said Qualification.

CONSENT AND AUTHORIZATION: I hereby authorize the requester identified above, or any representative designated in writing by that requester, to consult with **(provider)**_____ its relevant hierarchy, staff and Faculty, in order to obtain any and all information, documents, syllabi, teaching methodology and records concerning" my professional performance; competence, character, qualifications, work/teaching experience and behavior while a residelit *and/or* fellow, specifically including the circumstances of my departure from the institution. I hereby consent to the release of any and all information, records, documents, and/or opinions that PM&DC may require in their sole discretion and this may be provided to the PM&DC(requestor) pursuant to this authorization. I further consent to the copying of documents by **(provider)** _____ its relevant hierarchy, staff and Faculty, and transmittal to the requester or its representatives, of any and all records syllabus and teaching methodology, documents, *and/or* opinions described in the paragraphs above, as well as any other information, documents and/or opinions that may be material to an evaluation of my professional qualifications in order for PM&DC to consider it for registration and my competence to practice medicine, my qualifications to obtain or hold clinical privileges or professional credentials, and my moral and ethical qualifications for employment. I hereby consent to the consultation and to the provision of information, records, documents, *and/or* opinions described above to the requester now, or at any time in the future, in the event of a subsequent inquiry or request. I further consent to a supplemental consultation and to the provision of supplemental information, syllabus and teaching methodology records, documents, *and/or* opinions at any time in the future in the event that the **(requestor)** _____its relevant hierarchy, staff and Faculty, in their sole discretion, determines for any reason that information or opinions it has previously provided pursuant to this release are no longer complete, accurate, or timely, or that such information should be amended to make it more complete, accurate, or timely.

WAIVER OF LIABILITY: I hereby release the **requester,** _____ its relevant hierarchy, staff and Faculty, and their respective representatives from all liability, to the fullest extent permitted by the law, for any and all acts performed under this authorization, specifically including the provision of information, documents, or records pursuant to this request.

RELEASE AND WAIVER OF ALL CLAIMS: I specifically waive any claim for damages of any kind against **(provider)** _____ its relevant hierarchy, staff and Faculty, for acts performed pursuant to this authorization, to the fullest extent permitted by the law, including but not limited to claims of interference with contract, invasion of privacy, defamation, slander, discrimination, denial of employment, admission, licensure, or credentials, or negligence of any kind in the communication of such information to the requester or its representatives.

HOLD HARMLESS AND INDEMNIFICATION: I hereby agree to hold **(Provider)** _____its relevant hierarchy, staff and Faculty, and their representatives harmless from any and all claims made against them by me, the requester, or any other person or entity as a result of the release of information, documents, or records pursuant to this authorization. Specifically included in "hold harmless and indemnification" within this paragraph are any claims arising from denial of employment, admission, or credentials to me-by the requester or its representatives. I further specifically agree to indemnify **(Provider)** _____its relevant hierarchy, staff and Faculty and their Representatives for any and all legal fees, costs, or any other expenses incurred in defending any claim arising from the release of information, records, or documents sought by this request or provided pursuant to this authorization.

I shall pay fee for this verification to the provider if any

Signature of Authorizing Physician _____ Date _____

Print Name of Authorizing Physician _____

DOCUMENTS CHECK LIST / INSTRUCTIONS

(Please check the respective box: In case your documents are not complete or attached or attested, your application will be sent back un- actioned in original)

	For Applicant	*For Office*
1. Application form PMDC-VI for recognition of foreign/overseas postgraduate qualification in quadruplicate (four copies) for each qualification separately duly filled in and signed by the doctor along with "Consent to release of Information and release of Liability form".	☐	☐
2. Registration fee Rs.1000/- through Bank Draft in the name of Pakistan Medical & Dental Council Islamabad for each qualification.	☐	☐
3. Processing fee of Rs.5000/- in addition to Registration Fee (non-refundable) (totalling to Rs.6000/-)	☐	☐
4. Fee of Rs.200/- per year will be charged from the date of qualification.	☐	☐
5. Seven passport size photographs duly attested by authorized officer of Pakistan Embassy in that country OR by an authorized officer of Ministry of Foreign Affairs in Pakistan OR by any registered medical / dental practitioner with a valid registration with white background and both ears are visible.	☐	☐
6. Four Photostat copies of diploma / degree duly attested by person specified above. Each page should be attested separately. In case the degree is in the language other than English then four copies of authenticated English translation along with one copy of degree in original language.	☐	☐
7. Attested copy of syllabus/University calendar in English language. In case the same is in language other than English then copy of authenticated English translation along with one copy of syllabus/ university calendar in original language.	☐	☐
8. Registration Certificate of Pakistan Medical & Dental Council.	☐	☐
9. Proof of registration of the qualification and person with the registering/licensing body in the country of origin if available. Please attach Photostat copy duly attested by the person specified above.	☐	☐
10. Foreign Nationals and Pakistani doctors applying from foreign countries should pay equivalent amount in foreign exchange through Bank Draft/Cashier's Cheque of a recognized bank payable in Pakistan in favour of bank account titled "PAKISTAN MEDICAL & DENTAL COUNCIL" (without mentioning account number). For further details to submit fee while being abroad kindly visit our website.	☐	☐
11. Verification fee of £10/- for MRCP (UK) and £15/- for qualifications from University of London in their names along with a duly signed copy of verification request form of PM&DC.	☐	☐

RCPE

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

ROYAL COLLEGE OF PHYSICIANS OF LONDON

INDIVIDUAL VERIFICATION REQUESTS

- **All Sections must be completed in full. In completing this form you give your consent to confirm your MRCP(UK) or SCE qualification to an organisation or third party.**

SECTION 1 – Request for information

Please see Notes Section 1 for information and advice on completing this form.

DOCTOR'S FULL NAME (As appears on MRCP(UK) / SCE Certificate)

FAMILY NAME

CURRENT NAME (If different)

ADDRESS

QUALIFICATION

YEAR OBTAINED

RCP CODE NUMBER

DATE OF BIRTH (dd/MMM/YYYY)
e.g 12/06/1987 or 12 June 1987

GMC NUMBER (If known)

Are you a subscriber to Collegiate Membership?

Yes ☐ No ☐

If a Collegiate Member, which College do you pay your subscription fee? (Please tick appropriate box below)

RCP Edinburgh ☐ RCP&S Glasgow ☐ RCP London ☐

RCPE

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

ROYAL COLLEGE OF PHYSICIANS OF LONDON

SECTION 2 – Address where verification letter should be sent

Please complete this section if you wish the verification letter to be sent to a different address to that given in Section 1.

CONTACT FULL NAME

ORGANISATION

REFERENCE NUMBER (If applicable)

FULL ADDRESS

POST CODE/ZIP CODE

CITY

EMAIL ADDRESS

TELEPHONE

FAX

PAYMENT FORM WITH CC OR CHEQUE ATTACHED (If you are not a collegiate member or if the request for verification is being made through a third party)

Yes ☐ No ☐

The fee for a verification request is £10.00 GBP (except for Collegiate members who are exempt), and can be paid by credit card http://www.mrcpuk.org/SiteCollectionDocuments/Card%20Payment%20Form_231008.pdf or by cheque/banker's draft.

Please post or fax the completed form and the completed credit card payment form/cheque/banker's draft (if applicable) to:

Verifications Section
Examinations Department
Royal College of Physicians
11 St Andrews Place
Regent's Park
LONDON
NW1 4LE

Fax number: 0207 486 8401

If submitting a cheque or bankers draft, please write your full name and RCP Code number details on the reverse of the cheque or draft. Please allow 28 days for the completed request. Verification confirmations will be posted to requestors on headed notepaper.

RCPE

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

ROYAL COLLEGE OF PHYSICIANS OF LONDON

NOTES SECTION 1 – Request for Doctor information

In Section 1 please enter your details in full.

- **Full Family Name**: Please enter the your full name as appears on their Primary Medical qualification/MRCP(UK) certificate or Specialty Certificate Examination diploma.
- **Date of Birth**: Please enter your date of birth details. This is an essential requirement

RCP Code Number (if known): please enter your Royal College of Physicians code number.

- **Qualification and Year obtained**: Please enter details of the qualification you would like verified – (MRCP(UK) or SCE). Please add year qualification was obtained (if known).

GMC number (if known): Please enter your GMC registration number.

- **Subscriber to Collegiate membership**:

  If you are a doctor who is a Collegiate Membership subscriber, please tick the yes box and give details of the College to which you pay your Collegiate Member subscription. Please submit your request form by post or email mrcpverifications@mrcpuk.org

  If you are a doctor who does not pay a Collegiate Membership subscription or your Collegiate Membership subscription has expired you are required to pay a verification fee of £10.00 GBP and submit payment with this request form by post or by fax.

NOTES SECTION 2 – Address to which the verification letter should be sent

- **Payment Section:** Please enter sum of payment enclosed in GBP sterling. Payment must be submitted with every verification request submitted by any doctor who does not currently subscribe to Collegiate Membership with any of the Royal Colleges of Physicians and can be made by credit card (see credit card payment form), cheque or draft. The verification fee is £10.00 per doctor per request.
- **When paying by cheque or bankers draft, please ensure that your full name and RCP Code number details are written on the reverse of the cheque or draft.**

TO BE' COMPLETED BY ALL APPLICANTS (EMAILED) E I

DJ 07 TT PH7 1VL

UNIVERSITY OF LONDON
Fee for Third Party/Institutions Letter of Confirmation Request

SECTION A: For completion by ALL applicants

NAME OF STUDENT: _____

QUALIFICATION: _____

NAME OF APPLICANT/THIRD PARTY: _____

ADDRESS OF APPLICANT/THIRD PARTY: _____

_____

EMAIL ADDRESS:- _____

FOR OFFICIAL USE ONLY

IMPORTANT
Remittance should be sent by sterling cheque or postal orders made payable to the University of London and crossed 'Natwest Bank a/c payee'. Fees may also be paid by Mastercard, Visa or Switch/Maestro (UK only).

Formal receipts will not be sent unless specially requested.

Amount of fee enclosed
£15

Payment Method:
Card/Cheque(or draft)/Online/Other .....
(strike out words which do not apply)

EITHER COMPLETE SECTION B *OR* SECTION C

Section B **For online payments only**

Please insert your five digit transaction code here ☐☐☐☐☐

Section C

For credit/debit card payments not made online only THIS SECTION MUST SHOW CREDIT CARD DETAILS AND *ORIGINAL SIGNATURE* OF THE *CARDHOLDER.*

PAYMENT BY CREDIT CARD: *(please tick box as appropriate)* **Mastercard** ☐ **Visa** ☐ **Switch/Maestro** *(U.K. only)* ☐ **Solo** *(UK only)* ☐

CARD NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EXPIRY DATE ☐☐☐☐ **START DATE IF SHOWN** ☐☐☐☐

SWITCH CARD ISSUING NUMBER *(If indicated on card, U.K .only)* ☐☐

NAME OF ISSUING BANK _____

CARDHOLDER'S NAME AND INITIALS _____

CARDHOLDER'S BILLING ADDRESS _____

_____

_____

CARDHOLDERS SIGNA TURE _____