BARBADOS MEDICAL COUNCIL
MINISTRY OF HEALTH

APPLICATION FOR CERTIFICATE OF GOOD STANDING
(PLEASE PRINT INFORMATION CLEARLY)

SURNAME NAME: ..... **FIRST NAME:** .....

OTHER NAMES: ..... **MALE:** ☐ **FEMALE:** ☐

DATE OF BIRTH: ..... **COUNTRY OF BIRTH:** .....

PRACTITIONER'S MEDICAL REGISTRATION NO.: .....

PRACTITIONER'S ADDRESS: .....

.....

TELEPHONE NOS.: (W) ..... **(H)**..... **(C)** .....

EMAIL ADDRESS: .....

FORWARDING ADDRESS FOR CERTIFICATE OF GOOD STANDING: .....

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PRIMARY QUALIFICATION; INSTITUTION OBTAINED & DATE: .....

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SPECIALIST QUALIFICATION; INSTITUTION OBTAINED & DATE: .....

.....

DATE OF FULL REGISTRATION: .....

DATE OF LAST RENEWAL OF REGISTRATION: .....

SIGNATURE: ..... **DATE:** .....