



DELHI MEDICAL COUNCIL
Room No. 368, 3rd Floor, Pathology Block
Maulana Azad Medical College, Bahadur Shah Zafar Marg,
New Delhi 110 002 Tel. : 23237962 Fax : 23234416
Email : delhimedicalcouncil@gmail.com
Website : delhimedicalcouncil.nic.in

Receipt No. _____
Date _____

Bank Draft No. _____ Date _____

APPLICATION FORM FOR REGISTRATION

1. Name of the Applicant (In block letters)

- First Name : _____ Middle Name: _____ Surname : _____
- Maiden Name (in case of married women) :

2. Father's Name :

3. Gender : Male / Female

4. Address (Mailing Address): _____ Permanent Address: _____

5. (a) Telephone Number : _____ (b) Mobile No: _____ (c) E-mail Address : _____

6. Date and Place of Birth :

7. Nationality : Whether Indian by birth/by Domicile. If by Domicile, state date of becoming Indian citizen

8. Details of Internship :

9. Details of Qualifications :

S.No	Description of the qualification	Name of the College/Medical Institution	Name of the University/Licensing Body	Year of completion of Internship in case of MD Physician/in any other case year of passing examination

10. Details of Provisional Registration / Registration with any other Council :

11. Address of the Clinic/Hospital/Institute where practicing or in service:

I submit herewith original certificates for verification and submit attested copies of the following document/certificates : -

- a) Four recent passport size photographs with name and signature at the backside.
- b) State Medical Council/Medical Council of India Registration Certificate with MD 'Physician Qualification
- c) Degree/Diploma and Mark Sheet of MD 'Physician' qualification (if the same in as language other than English then an authentic translation in English)
- d) Internship Completion Certificate
- e) Screening Test Copy
- f) 10th Mark Sheet and passing certificates or equivalent examination.
- g) 12th Mark Sheet and passing certificates or equivalent examination.
- h) Birth certificate/matriculation certificate/SSC Exam certificate/School Leaving certificate with date of Birth.
- i) Copy of the passport in possession duly attested by a Gazetted Officer (From first page to last page with English Translation of the contents in the passport)
- j) Other evidence in support of my having obtained the qualification which I possess in original

Note:- Application for registration is to be submitted in Person

I hereby submit a **Bank Draft** No. dateddrawn on Bank for **Rs. 1,000/-** (Rupees One Thousand Only) as non-refundable fee **in favour of "Delhi Medical Council"** payable at New Delhi.

Date :

(Signature of the Applicant)

DECLARATION

I solemnly affirm & declare that the above entries made by me are true & correct. I further declare that no disciplinary proceedings have ever been initiated or are pending against me before any medical regulatory authority nor I have been subject to any inquiry or investigation before any authority which may disentitle me from seeking registration with Delhi Medical Council. I undertake to abide by the Code of Conduct & Ethics prescribed by Delhi Medical Council and Medical Council of India.

Note:- In case you have ever been fined, given a warning/reprimanded/suspension of registration temporary/permanent, by any medical, health or any regulatory authority or has been held guilty of medical malpractice or negligence by any Court of Law, you must provide the full details on a separate sheet to the Delhi Medical Council.

Date :

(Signature of the Applicant)

(For Office use only)

S.No. of Registration Certificate Issued _____ dated.

Acknowledgement of receipt of Registration Certificate.

Received the above document in original.

Signature of registered person _____

Name _____

Date _____