



Medical Board of Trinidad & Tobago

Postgraduate Assessment Form For Independent Specialist Practice

Name: _____

Date of Birth: _____

Registration Class: _____ **Registration Number:** _____

Current Place of Employment _____

Registered Qualifications & Year of Graduation

1. _____
2. _____
3. _____
4. _____
5. _____

Additional Qualification for which assessment is being sought:
