



# **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:**

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