**APPLICATION FOR TEMPORARY REGISTRATION**

**WITH THE MEDICAL BOARD OF TRINIDAD AND TOBAGO**

I, …… hereby apply for
*(Name in Block Letters)*

Temporary Registration with the Medical Board of Trinidad and Tobago, by virtue of the following qualifications of which I am lawfully possessed.

| Description of Qualifications | Date of Qualifications |
|---|---|
| | |

Place and Date of Applicant's Birth ……..

Applicant's Ordinary Address ……
……
……

**I DO HEREBY CERTIFY THE ABOVE INFORMATION TO BE TRUE**

Date of Application …….. Signature ……

Email Address ……..

Contact Number(s) ……..

*Applicant must submit with this Application:-*

- Satisfactory Evidence of Identity (Passport, Driver's Permit or National Identification Card).
- Satisfactory Evidence of Good Character.
- Qualifying Diploma and satisfactory evidence that he/she is to be employed in an approved hospital or institution.
- Letter of Good Standing (not more than three (3) months old from your last Registration body.
- Two (2) passport size photographs (if not previously produced to the Medical Board of Trinidad and Tobago).
- Prescribed Fee of One Thousand and Eight Hundred Dollars ($1,800.00) – ($800.00 Registration Fee and $1,000.00 license to practice for the current year).

Receipt No. ……

This Registration gives permission to practice in the following institutions: -

- General Hospital: Arima, Port-of-Spain, San Fernando
- County Hospitals: Scarborough, Tobago and Sangre Grande
- Area Hospital: Point Fortin, Approved Public Health Facilities
- Caribbean Epidemiological Center (C.A.R.E.C.), St. James Medical Complex
- Caura Chest Hospital, St. Ann's Psychiatric Hospital
- Eric Williams Medical Sciences Complex, Mt. Hope Maternity Hospital
- Queen's Park Counseling Center (Q.P.C.C.)

**CERTIFICATE OF GOOD CHARACTER**

I, ……

*(Name in Block Letters)*

residing at …….

……..

hereby certify that I have known the applicant:

……..

*(Name of Applicant)*

for the past ……. years. I further certify that he/she is of good character and a fit and proper person to be admitted to the medical profession in Trinidad and Tobago.

Signature ……

Qualifications ……..

Date ……..

**N.B. The signatory must be well acquainted with the applicant for at least five (5) years and be a Physician registered to practice medicine.**

**CERTIFICATE OF IDENTITY**

I, ……

*(Name in Block Letters)*

residing at ……..

……

hereby certify that I have known the applicant:

……..

*(Name of Applicant)*

for the past …….. years.

Signature ……..

Qualifications ……..

Date ……

**THE ACCOMPANYING PHOTOGRAPHS MUST BE SIGNED BY THE PERSON WHO HAS SIGNED THE <u>CERTIFICATE OF IDENTITY</u> WITH THE FOLLOWING WORDS INSERTED AT THE BACK OF EACH PHOTOGRAPH :-**

**"I hereby certify that this is a true likeness of the applicant ……..**

**(NAME)**

**Signature…….. Date ……."**

**N.B. The signatory must be well acquainted with the applicant for at least five (5) years and be a Physician registered to practice medicine.**

**DECLARATION OF APPLICANT**

**I …….. do solemnly promise**
***(Name of Applicant)***

**to abide by the laws governing the practice of medicine in Trinidad and Tobago and further promise to observe and abide by the Code of Ethics of the Medical Board of Trinidad and Tobago, and understand that I will be subject to any sanctions and/or penalties as proscribed by the Medical Board of Trinidad and Tobago where I have been found to be in breach of such laws and regulations.**

**Signature …….**

**Date ……**

**---ooo---**

**<u>For official Use Only:</u>**

- **Approved at Regular Monthly Meeting on ……..**
  **(Day/Month/Year)**
- **Officially recorded as per Meeting No. ……..**

**…….**
**Secretary/Treasurer**

Kindly indicate **YES** or **NO** to questions 1-2 below, if YES please enter details.

**1.** **YES ☐** **NO ☐**

Have you ever been suspended, restricted, or revoked of your licensure, registration, permit or any other authority to practice medicine in another jurisdiction?

IF YES:
Effective Date of Disciplinary Action: _____

Country: _____ State/Province: _____

Name of Medical Board/Council: _____

Reason for suspension/revocation/restriction of license/registration/permit.
(Circle the appropriate category)

_____
_____
_____
_____
_____

**2.** **YES ☐** **NO ☐**

Have you ever been denied an application for licensure, registration, permit or any other authority to practice medicine in another jurisdiction?

IF YES:
Date of official Notice of denial: _____

Country: _____ State/Province: _____

Name of Medical Board/Council: _____

Reason for denial of license/registration/permit.
(Circle the appropriate category above)

_____
_____
_____
_____

Kindly indicate **YES** or **NO**, if YES please enter details.

**3.** **YES ☐ NO ☐**

Have you ever been found guilty of professional misconduct, conduct unbecoming, incompetence or an incapacity or lack of fitness to practice medicine in another jurisdiction?

IF YES:

Date of Medical Board/Council's decision: _____

Country: _____ State/Province: _____

Name of Medical Board/Council: _____

Explanation of above Medical Board/Council's pronouncement of guilt of professional misconduct/ conduct unbecoming/ incompetence/ an incapacity/ lack of fitness to practice medicine.

(Circle the appropriate category above)

_____
_____
_____
_____
_____

**4.** **YES ☐ NO ☐**

Do you have a health condition that may impact on the safe performance of your duties as a medical practitioner?

IF YES or you are unsure:

Please provide a medical report from a specialist in the relevant field of medicine.

Kindly indicate **YES** or **NO**, if YES please enter details.

**5.** **YES☐ NO☐**

Are you currently or have you been under investigation or other proceeding in relation to your conduct, competence or capacity or fitness to practice medicine in another jurisdiction?

IF YES:
Date of investigation/proceeding: _____

Country: _____ State/Province: _____

Name of Medical Board/Council: _____

Explanation of above Medical Board/Council's investigation/proceeding in relation to your conduct/ competence/ capacity/ fitness to practice medicine.
(Circle the appropriate category above)

_____
_____
_____
_____
_____

Kindly indicate YES or NO, if YES please enter details.

**6.** **YES ☐** **NO ☐**

Have you ever been reviewed of your conduct, competence or capacity or fitness to practice, whether arising from a complaint or otherwise in another jurisdiction?

IF YES:
Date of review: _____

Country: _____ State/Province: _____

Name of Medical Board/Council: _____

Explanation of above Medical Board/Council's review in relation to your conduct/ competence/ capacity to practice medicine/ fitness to practice medicine.
(Circle the appropriate category above)

_____
_____
_____
_____
_____

**7.** **YES ☐** **NO ☐**

List all other Medical Councils/Organizations where you are registered:

i _____
ii _____
iii _____
iv _____
v _____
vi _____
vii _____
viii _____
ix _____
x _____

**8.** **YES ☐** **NO ☐**

I hereby agree that I have read the Code of Ethics online (www.mbtt.org)