**Medical and Dental Student Annual Registration**

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Please include a photo not more than a month old

**For registration of Student License.** Additional details should be added on separate paper and sent via email. Forms to are to be dropped to the Secretariat Office or posted at P. O. Box 18914, Suva.

All sections are compulsory. Use N/A if a Section is Not Applicable. **INCOMPLETE FORMS WILL NOT BE PROCESSED**.

***NOTE: You are to inform the Secretariat within 30 days whenever there is any change in the information provided in this form.***

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| 1. **PERSONAL INFORMATION**
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| Surname: Click or tap here to enter text.Forenames: Click or tap here to enter text.Other Names: Click or tap here to enter text. | Student Number: Click or tap here to enter text.Medical [ ]  Dental [ ]  |
| Residential Address: Click or tap here to enter text. | Postal Address: Click or tap here to enter text. |
| Telephone: Click or tap here to enter text.  Mobile: Click or tap here to enter text. Email: Click or tap here to enter text. |
| Next of Kin: Click or tap here to enter text. Relationship: Click or tap here to enter text.Address: Click or tap here to enter text.Phone: Click or tap here to enter text. Email: Click or tap here to enter text. |
| 1. **REGISTRATION**
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| **Reason for seeking student registration**: (Give Name of perspective institution/ course enrolled for / sponsoring agency / place of study/ details of project / any other reason. Institute: Click or tap here to enter text.Program: Click or tap here to enter text. Year: Click or tap here to enter text.  |
| 1. **EDUCATION**
 |
| **Date** | **Qualification Gained** | **Full Name and Location of Institution** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 1. **OTHER ACHIEVEMENTS & SKILLS (IN ANY FIELD)**
 |
| Click or tap here to enter text. |
| 1. **ACADEMIC OR OTHER DISCIPLINARY EQUIRIES AND CHARGES (CONCLUDED& PENDING) AT MEDICAL INSITUTE**
 |
| **Date** | **Country** | **Details & Outcome** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 1. **MEDICAL FITNESS TO PRACTISE**
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 Have you previously suffered or currently suffer from an injury or illness or condition(s) which may place you at an increased risk or harm? Yes [ ]  No [ ]

 If YES, please detail conditions (include date of injury/illness/medication taken)

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| Click or tap here to enter text. |

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| 1. **CRIMINAL / TRAFFIC CONVICTIONS**
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 Are you facing any criminal, drug or alcohol related charges? Yes [ ]  No [ ]

 If YES, please provide details:

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| Click or tap here to enter text. |

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| 1. **DECLARATION BY APPLICANT (Should be signed & dated for application to be considered complete)**
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* I undertake to comply with all relevant legislation and Council guidelines, regulations, codes & standards;
* I undertake to provide the Council/Secretariat police clearance reports from all jurisdictions should the Council seek such documents;
* I undertake to provide the Council/Secretariat medical reports or any report should the council seek such documents;
* I undertake to inform the Council within 30 days should any of the details at any time change than that be stated on this form;
* I consent to the Secretariat divulging relevant practice details as it sees fit;
* I consent to the Secretariat verifying any information provided by me in the form
* I Make this declaration in the knowledge that information provided are true & correct &
* undertake to uphold the medical and dental profession in high esteem.

 Signed: …………………………………………………………. Date: Click or tap to enter a date.

**PLACING YOUR NAME BELOW CONSTITUTES YOUR ELECTRONIC SIGNATURE.**

Name: Click or tap here to enter text. Place: Click or tap here to enter text.

**WARNING: False / Fraudulent Claims:**  In the event of any applicant submitting false or incomplete data, and or copies of certificates, which are found to be false, The Medical and Dental Registration authority of the applicant will be notified. The application for registration in Fiji will be unsuccessful; or provisional registration, if already given, will not be confirmed, and may be cancelled. Council/Secretariat may require further information before a decision is made.

**Supporting Documents Required: (Compulsory)**

Please submit copies of the following documents with this application:

1. Recent Coloured Passport Photo
2. Copy of Student Offer Letter (Year 1)
3. Enrolment Registration (Year 2 – Year 6)
4. Copy of Student ID

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| 1. **PAYMENT**
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A fee schedule is provided below and can be viewed on our website. Please make any cheques payable to the Secretariat of the Fiji Medical & Dental Councils. Should you wish to make direct payment, **add your details in the payer section (Practitioners Registration Number & Name)** & deposit the fee in our **ANZ Account # 10737532**. ANZ Swift Code: ANZBFJFX. Evidence of payment must be emailed to **accountant@fijimds.com** ***and* attached with the application form.**

**Preferred method of payment**

[ ]  Transfer Credit on our ANZ **Account # 10737532** [ ]  EFTPOS **(at Secretariat-Charges may apply)** [ ]  **CHEQUE**

***NOTE: For an application form to be complete, the applicable fee for the registration/license must be paid and attached with this annual renewal form.***

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| 1. **FEE SCHEDULE**
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| **DESCRIPTION** | **RATE (FJD)** |
| Medical Students – Year 1 – 6 (Annual Registration) | $10 |
| Dental Student– Year 1 – 5 (Annual Registration) | $10 |