**NEW DENTAL AND MEDICAL PRACTITIONERS**

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Please include a photo not more than a month old

Additional details to be included on a separate paper and attached to this form.

The form is to be dropped off at the Office of the Secretariat **OR** posted to P. O. Box 18914, Suva **OR** emailed to info@fijimds.com

All sections are compulsory. Use N/A if a Section is Not Applicable.

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

**Year of Registration:**

**Do you wish to practise? YES** [ ]  **NO** [ ]

**If “YES” – INDEMNITY INSURANCE will be required for ANNUAL PRACTICE LICENSE. Refer to Sec 10 of Form**

**If “NO” – INDEMNITY INSURANCE is not required and Registration can be maintained.**

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| 1. **PERSONAL INFORMATION**
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| Surname: Forenames: Other Names:  | Tax Identification Number: Registration Number:  |
| Date of Birth:  | Sex:Female [ ]  Male [ ]   | Country of Citizenship:  |
| Residential Address:  | Postal Address:  |
| Telephone: Work: Mobile: Email:  |
| Passport Number:  | EDP Number:  |
| Language Spoken:  | FNPF Number:  |
| Next of Kin: Relationship: Address: Phone: Email:  |
| 1. **MEDICAL AND DENTAL REGISTRATION HELD IN FIJI AND ELSEWHERE**
 | Click or tap here to enter text. | Click or tap here to enter text. |
| Date of Entry | Registering Authority | Name of Nation / State | Valid Until | General / Specialist |
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| 1. **Primary Qualification**
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| Qualification Gained: Institute: Years & Length of program: Clinical instruction received at: Language of instruction of course:  |
| 1. **REGISTRATION**
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| Category[s] of Registration sought:[ ]  Conditional [ ]  Provisional [ ]  General Practise [ ]  Vocational Registration in the field of [ ]  Temporary from …. /…. / Until …. /…. (Relevant to specific projects, duration less than 3months**Reason for Seeking Registration**: (Give Name of Prospective employer / sponsoring agency / place of practise / details of project/ renewing annual registration or any other reasons.  |
| 1. **CONTINUING PROFESSIONAL DEVELOPMENT –** List all CPD activities in the last 12 months. Use separate page if required providing documentary evidence

***(Minimum: 25 hours for Medical Practitioners and 10 hours for Dental Practitioners per annum)*** |
| **Date** | **Activity** | **Hours** |
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| 1. **PROFESSIONAL INDEMNITY**
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 Do you have Professional Indemnity Insurance? Yes [ ]  No [ ]

 Please provide the details and evidence. ***NOTE: It is UNLAWFUL to practise without Professional Indemnity (Insurance)***

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| 1. **CRIMINAL/ OTHER 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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| 1. **DECLARE INTEREST IN RELEVANT BUSINESS**
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| Section 93 of the Medical & Dental Practitioner Act 2010 requires a registered person or close relative to declare interest in a relevant business. Please provide details:  |
| 1. **DECLARATION BY APPLICANT (Should be signed & dated for application to be considered complete)**
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* I undertake to display my Annual Practice Certificate in the Public area of my Practice;
* 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 Dental reports or any report pertaining to the practice 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 undertake to cooperate with the Council/Secretariat in all matters pertaining to complaints and disciplinary proceedings;
* I consent to the Secretariat to divulge relevant practice details as per the Medical & Dental Practitioner Act 2010;
* I declare that I am fit for practise in the vocation I am applying for;
* I make this declaration in the knowledge that a false statement may amount to perjury and revoke my Practising Certificate;
* I solemnly declare to the best of my knowledge that all information provided is true and correct;
* I undertake to uphold the Medical / Dental profession in the highest esteem.

 Signed: …………………………………………………………. Date:

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

Name: Place:

**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 Registration authority of the applicant’s citizenship 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.

Note 1: The Fiji Medical and Dental Council will determine your eligibility for registration.

 If you are found to be eligible, your registration will be confirmed when you present your original documents, or original notarized copies of the same, to the Registrar, Respective Council, for inspection of the copies you have submitted

Note 2: It is normal practice for the doctors coming outside Fiji on first appointment to be granted provisional registration for a period of four months, which will be confirmed subject to satisfactory performance.

Note 3: Applications for Temporary Registration, for visit by consultants for specific projects must be accompanied by letters of recommendation from the practitioner, resident in Fiji, who is responsible for the project

**Supporting Documents Required:**

Please submit copies of the following documents with this application:

1. Certified copy of Basic qualification and other qualification gained.
2. Recent coloured passport photo
3. Certificate of ‘good standing’ from the Medical/Dental Registration authority **IF** you practised outside of Fiji in the previous year; dated not more that 3 months before the date of application.
4. Copies of Valid Practising License from your country of residence (**Only for overseas applicants)**
5. Work Permit **(Non- Fiji citizen)**
6. Evidence of Professional Indemnity;
7. Completed documentation of Continuing Professional Development **(‘CPD’)** signed by Department Supervisor or Certificates Attained.
8. Copies of Provisional Offer of Appointments (Place of Practise)

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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 **info@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 registration form.***

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| 1. **FEE SCHEDULE**
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| **DESCRIPTION** | **RATE (FJD)** |
| Application fee Registration – resident | 20 |
| Application fee Registration – non-resident | 100 |
| Medical / Dental Practitioners in Government Services (Practice License Fee) | 200 |
| Medical / Dental Practitioners in Private Practice (Practice License Fee) | 200 |
| Vocational Registration – Medical / Dental Practitioners (Practice License Fee) | 300 |
| Dental Therapist/ Dental Hygienist/ Dental Technician (Practice License Fee) | 50 |