GENERICAPPFORM REFERENCE NUMBER: | | | | | | |

Comhairle na nDochtúirí Leighis
Medical Council

Kingram House, Kingram Place, Dublin2, Ireland.
Telephone: +353-1-4983100
Facsimile: +353-1-4983102
Email: registration@mcirl.ie
Website: www.medicalcouncil.ie

APPLICATION FORM FOR REGISTRATION IN THE REGISTER OF MEDICAL PRACTITIONERS

DO NOT SUBMIT YOUR APPLICATION FORM WITHOUT ENCLOSING ALL OF THE REQUIRED DOCUMENTATION.

IF DOCUMENTS ARE MISSING, IF COPIES OF CERTIFICATES ARE NOT CERTIFIED AS TRUE COPIES OF ORIGINALS, OR IF THE FORM IS NOT FULLY COMPLETED, YOUR APPLICATION WILL BE REJECTED AS INVALID AND RETURNED.

ALL 12 PARTS OF THIS APPLICATION FORM MUST BE COMPLETED INCLUDING THE CHECKLIST(S)

1. WHICH CATEGORY?

PLEASE TICK THE MOST APPROPRIATE CATEGORY FOR YOUR APPLICATION BELOW:

	CATEGORY 1: Graduate of Medical School in Ireland (UCD, UCC, NUIG, TCD, RCSI or UL). **Please see website for current fees.**
	CATEGORY 2: EU/EEA or Swiss citizen qualified in an EU/EEA member state or in Switzerland. **Please see website for current fees.**
	CATEGORY 3: Non-EU citizen who qualified in an EU/EEA member state or in Switzerland. **Please see website for current fees.**
	CATEGORY 4: Graduate of a medical school in a third country (outside EU/EEA/ Switzerland) and qualification listed in Avicenna **Please see website for current fees.**

Please affix firmly a recent passport-size colour photograph of yourself HERE

NOTES: THE REGISTRATION YEAR RUNS FROM 1ST JULY TO 30TH JUNE EACH YEAR. IF A DOCTOR IS REGISTERED DURING THE REGISTRATION YEAR, A RETENTION FEE IS PAYABLE ON THE FOLLOWING 1ST JULY. [PLEASE SEE IMPORTANT NOTE ON PAGE 17.]
+ IF REGISTRATION IS GRANTED, ITEMS MARKED + WILL APPEAR ON THE REGISTER OF MEDICAL PRACTITIONERS.
° IF REGISTRATION IS GRANTED, ITEMS MARKED ° MAY BE SHARED WITH RELEVANT THIRD PARTIES, EG TRAINING BODIES/ HSE

2. WHICH DIVISION?

HAVE YOU COMPLETED SPECIALIST TRAINING?

☐ Yes ☐ No (Please tick appropriate box)

IF YOU ANSWER YES, THIS IS THE WRONG FORM. PLEASE COMPLETE THE **SPECIALIST APPLICATION FORM**.

ARE YOU SEEKING REGISTRATION IN TRAINING POSTS? (SPECIALIST TRAINING)

☐ Yes ☐ No (Please tick appropriate box)

IF YES, **CATEGORY 4** APPLICANTS PLEASE CHECK YOUR ELIGIBILITY FOR TRAINEE SPECIALIST REGISTRATION BEFORE SUBMITTING. IF NO, **ALL APPLICANTS** -YOUR APPLICATION WILL BE CONSIDERED FOR REGISTRATION IN THE GENERAL DIVISION.

3. PERSONAL DETAILS

+ °TITLE: (please circle/ tick appropriate box) | Professor | Dr | Mr | Ms |

PLEASE TICK THE APPROPRIATE BOX BELOW TO INDICATE WHICH SURNAME YOU WISH TO HAVE ENTERED ON THE REGISTER:

+ °SURNAME ON YOUR DEGREE/DIPLOMA:

☐ | | | | | | | | | | | | | | | | | | | |

+ °CURRENT SURNAME IF DIFFERENT TO ABOVE:

☐ | | | | | | | | | | | | | | | | | | | |

***NOTE**: IF YOUR SURNAME IS DIFFERENT TO THE SURNAME WHICH APPEARS ON YOUR DEGREE/DIPLOMA (E.G. BY MARRIAGE) YOU MUST SUBMIT A NOTARISED/ATTESTED COPY OF YOUR STATE MARRIAGE CERTIFICATE OR DEED POLL. DOCTORS MUST PRACTISE IN THE NAMES IN WHICH THEY ARE REGISTERED - SEE PARAGRAPH 55 OF THE CURRENT GUIDE TO PROFESSIONAL CONDUCT AND ETHICS.*

+ °FORENAME(S) ON YOUR DEGREE / DIPLOMA: (one per line)

1																					
2																					
3																					
4																					

+ °**GENDER:** (please circle/tick appropriate box)

MALE	**FEMALE**

°**DATE OF BIRTH:** D D M M Y Y Y Y

MOTHER'S MAIDEN SURNAME (I.E. HER BIRTH SURNAME, E.G. "SMITH"):

NOTE: IN ORDER TO VERIFY YOUR IDENTITY, YOU MAY BE ASKED FOR THE ABOVE INFORMATION WHEN YOU CONTACT THE MEDICAL COUNCIL.

+ °ADDRESS TO BE USED FOR ENTRY IN THE REGISTER TO WHICH ALL CORRESPONDENCE WILL BE SENT. [THE MEDICAL COUNCIL MUST BE ABLE TO CONTACT YOU AT THIS ADDRESS WHEN NECESSARY]:

Line 1:

Line 2:

Line 3:

Line 4:

City/State/County/Country:

***NOTE**: A DOCTOR'S REGISTERED NAME, ADDRESS AND QUALIFICATIONS ARE AVAILABLE TO THE PUBLIC AND ARE PUBLISHED ON OUR WEBSITE. HOWEVER A DOCTOR MAY ENTER ANY ADDRESS AT WHICH HE/SHE CAN BE CONTACTED BY THE COUNCIL. IT DOES NOT HAVE TO BE THEIR HOME ADDRESS. THE COUNCIL RECOMMENDS THAT DOCTORS ENTER THEIR PRACTICE ADDRESS AS THEIR REGISTERED ADDRESS.*

°**CONTACT DETAILS:** (PLEASE INCLUDE INTERNATIONAL CODES IF OUTSIDE THE REPUBLIC OF IRELAND)

Phone:																					
Mobile:																					
E-mail address:	*Contacting applicants about their application by email is often quicker than by post. Please also check your Spam and Junk email folders as some mail servers might mark our emails as spam.*																				

COUNTRY IN WHICH YOU WERE BORN:

°**COUNTRY / IES OF WHICH YOU ARE A CITIZEN:**

1																					
2																					

PASSPORT NUMBER:

EXPIRY DATE: D D M M Y Y Y Y

4. PROFESSIONAL QUALIFICATIONS

+ ° PRIMARY MEDICAL QUALIFICATION(S) (ABBREVIATIONS):

NOTE: THE QUALIFICATION TO BE ENTERED IS THE MEDICAL QUALIFICATION ON WHICH YOUR APPLICATION IS BASED, E.G. MBBS, MD, ETC

EXAMPLE:	M	B		B	C	h		N	U	I				

+ ° DATE OF CONFERRAL:

D D M M Y Y Y Y

DATE YOUR UNDERGRADUATE MEDICAL COURSE...

COMMENCED: M M Y Y Y Y **° ENDED:** M M Y Y Y Y

LANGUAGE OF INSTRUCTION DURING YOUR UNDERGRADUATE COURSE:

° COUNTRY IN WHICH YOU QUALIFIED:

° NAME AND ADDRESS OF MEDICAL SCHOOL: (PLEASE INCLUDE INTERNATIONAL CODES)

Name of Medical School:

Address:

CONTACT DETAILS OF MEDICAL SCHOOL: (PLEASE INCLUDE INTERNATIONAL CODES)

Email address:	
Phone:	
Fax:	
Name of University (if different from Medical School):	

NAME AND ADDRESS OF HOSPITAL(S) IN WHICH YOU COMPLETED YOUR INTERNSHIP TRAINING:

DATE YOUR INTERNSHIP TRAINING...

COMMENCED: M M Y Y Y Y **° ENDED:** M M Y Y Y Y

LANGUAGE OF INSTRUCTION DURING YOUR INTERNSHIP TRAINING:

5. POSTGRADUATE SPECIALIST TRAINING

ARE YOU REGISTERED WITH A POSTGRADUATE TRAINING BODY IN IRELAND?

☐ Yes ☐ No (Please tick appropriate box)

IF YES, PLEASE PROVIDE NAME AND ADDRESS OF THE TRAINING BODY:

HAVE YOU BEEN OFFERED A PLACE / ACCEPTED ON A POSTGRADUATE TRAINING PROGRAMME?

☐ Yes ☐ No (Please tick appropriate box)

6. REGISTRATION DETAILS

HAVE YOU APPLIED TO THIS MEDICAL COUNCIL BEFORE FOR ANY TYPE OF REGISTRATION,
(Please tick appropriate box/es)

☐ YES ☐ NO

HAVE YOU EVER BEEN GRANTED / HELD REGISTRATION IN THE REPUBLIC OF IRELAND?
☐ Yes ☐ No (Please tick appropriate box)

NOTE: YOU SHOULD COMPLETE THE **RESTOREAPP FORM** IF YOU HAVE PREVIOUSLY BEEN REGISTERED IN THE TRAINEE SPECIALIST OR GENERAL DIVISIONS OF THE REGISTER ON OR AFTER 16/03/09. IF YOU WERE LAST REGISTERED PRIOR TO 16/03/09 THIS IS THE CORRECT FORM.

+ ° REGISTRATION / REFERENCE NUMBER QUOTED TO YOU IN PREVIOUS CORRESPONDENCE:

PLEASE LIST ALL THE AUTHORITIES WITH WHICH YOU HAVE EVER BEEN REGISTERED FOR THE PURPOSE OF ENGAGING IN THE PRACTICE OF MEDICINE AS A REGISTERED MEDICAL PRACTITIONER:

AUTHORITY #1. NAME AND ADDRESS OF REGISTRATION AUTHORITY:
Name:

Address:

REGISTERED FROM D D M M Y Y Y Y To: D D M M Y Y Y Y

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

AUTHORITY #2. NAME AND ADDRESS OF REGISTRATION AUTHORITY:
Name:

Address:

REGISTERED FROM D D M M Y Y Y Y To: D D M M Y Y Y Y

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

AUTHORITY #3. NAME AND ADDRESS OF REGISTRATION AUTHORITY:
Name:

Address:

REGISTERED FROM D D M M Y Y Y Y To: D D M M Y Y Y Y

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

NOTE: IF REGISTERED WITH ANY ADDITIONAL AUTHORITIES, PLEASE CONTINUE ON A SEPARATE PAGE AND ATTACH

IMPORTANT PLEASE READ BEFORE CONTINUING

LIST ALL REGISTRATION AUTHORITIES WITH WHOM YOU HAVE HELD REGISTRATION IN THE LAST FIVE YEARS EVEN IF YOU HAVE NOT PRACTISED MEDICINE IN THAT COUNTRY.

PLEASE LIST ANY OTHER HEALTH RELATED AUTHORITIES WITH WHICH YOU HAVE EVER BEEN REGISTERED (EG PHARMACEUTICAL SOCIETIES, PHYSIOTHERAPISTS, ETC):

NAME AND ADDRESS OF AUTHORITY:
Name:

Address:

REGISTERED FROM	D	D	M	M	Y	Y	Y	Y	TO:	D	D	M	M	Y	Y	Y	Y

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

NOTE: IF REGISTERED WITH ANY ADDITIONAL HEALTH-RELATED AUTHORITIES, PLEASE CONTINUE ON A SEPARATE PAGE AND ATTACH.

7. EXEMPTION FROM THE PRE-REGISTRATION EXAMINATION SYSTEM (PRES)

TO BE COMPLETED BY ALL APPLICANTS

(please tick all boxes appropriate to you)

SEE REGISTRATION RULES 2011

I AM SEEKING EXEMPTION FROM THE PRES ON THE BASIS THAT:

	I meet the eligibility requirements for Categories 1, 2 or 3
	I was previously registered in the General Register of Medical Practitioners under the Medical Practitioners Act 1978 as provided for in Registration Rules 2(d) and 10(a)
	I have been awarded a postgraduate qualification as set out in Appendix A of the Registration Rules, or equivalent, **and** meet with the other registration criteria as provided for in Registration Rule 2(c) – **This exemption applies to the General Division only**
	I have been awarded a postgraduate qualification as set out in Appendix A of the Registration Rules, or equivalent, **and** have been awarded a document which is considered to be at least the equivalent to a Certificate of Experience – **This exemption applies to the Trainee Specialist Division.**
	I have been awarded a Certificate of Experience or equivalent certificate, as provided for in Registration Rule 3 – **This exemption applies to the General Division only.** **** THIS EXEMPTION WILL ONLY BE GRANTED TO APPLICANTS WITH AN OVERSEAS INTERNSHIP WHICH IS CURRENTLY RECOGNISED BY THE MEDICAL COUNCIL AS EQUIVALENT TO AN IRISH INTERNSHIP.** (Please refer to the Council's website for a list of overseas internships which are recognised as equivalent)

OR

	I AM NOT SEEKING EXEMPTION FROM THE PRES

PLEASE NOTE THAT MEDICAL PRACTITIONERS REGISTERED IN THE GENERAL DIVISION WHO WERE EXEMPT ON THE BASIS OF HAVING A CERTIFICATE OF EXPERIENCE OR EQUIVALENT, ARE NOT NECESSARILY EXEMPT FROM THE PRES IN ORDER TO BE REGISTERED IN THE TRAINEE SPECIALIST DIVISION.

APPLICANTS WHO DO NOT HAVE THE EQUIVALENT OF A CERTIFICATE OF EXPERIENCE ARE **NOT** ELIGIBLE FOR REGISTRATION IN THE TRAINEE SPECIALIST DIVISION**.**

8. IMPORTANT QUESTIONS

NOTE: *IT IS IMPERATIVE THAT YOU ANSWER **EACH** OF THE FOLLOWING **8** QUESTIONS BY TICKING THE APPROPRIATE BOX.*

Q.1 **HAVE YOU EVER BEEN CONVICTED IN A COURT OF LAW? (INCLUDING A DRUNKEN DRIVING CHARGE)** ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS OF YOUR CONVICTION ON A SEPARATE PAGE AND ATTACH.

Q.2 **HAVE YOU EVER BEEN DECLARED BANKRUPT OR HAD A CHARGE / JUDGMENT MADE AGAINST YOU?** ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS ON A SEPARATE PAGE AND ATTACH.

Q.3 **DO YOU NOW OR HAVE YOU EVER SUFFERED FROM A RELEVANT MEDICAL DISABILITY THAT MIGHT AFFECT YOUR COMPETENCE AS A MEDICAL PRACTITIONER?** [SEE PARAGRAPH 11 OF THE GUIDE TO REGISTRATION.] ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS, INCLUDING NAME, ADDRESS AND CONTACT DETAILS OF YOUR TREATING DOCTOR(S) IN THE SPACE PROVIDED ON PAGE 9 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.4 **HAVE YOU EVER BEEN TREATED FOR:**

(A) ALCOHOL DEPENDENCE? ☐ YES* ☐ NO

(B) DRUG DEPENDENCE? ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS, INCLUDING NAME, ADDRESS AND CONTACT DETAILS OF YOUR TREATING DOCTOR(S) IN THE SPACE PROVIDED ON PAGE 9 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.5 **HAVE YOU EVER BEEN REQUIRED TO UNDERGO REMEDIATION / RETRAINING FOLLOWING AN ASSESSMENT OF YOUR COMPETENCE / PERFORMANCE AS A MEDICAL PRACTITIONER BY A REGISTRATION AUTHORITY OR OTHER BODY RESPONSIBLE FOR CONDUCTING SUCH ASSESSMENTS?** ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS, INCLUDING THE NAME OF THE BODY WHICH CONDUCTED THE ASSESSMENT IN THE SPACE PROVIDED ON PAGE 9 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.6 **HAS ANY REGISTRATION AUTHORITY EVER REFUSED TO GRANT YOU REGISTRATION TO ENGAGE IN THE PRACTICE OF MEDICINE AS A REGISTERED MEDICAL PRACTITIONER?** ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS, INCLUDING THE REASONS FOR REFUSAL, IN A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.7 **HAVE YOU EVER BEEN DEPORTED AND / OR EXCLUDED FROM ANY COUNTRY?** ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS IN A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.8 **HAVE YOU EVER BEEN THE SUBJECT OF DISCIPLINARY PROCEEDINGS OR A COMPLAINT OR ARE ANY PROCEEDINGS OR COMPLAINTS IN PROGRESS OR PENDING NOW BY AN AUTHORITY WITH WHOM YOU ARE OR WERE REGISTERED OR EMPLOYED AS A MEDICAL PRACTITIONER? AND / OR HAS YOUR NAME EVER BEEN ERASED / SUSPENDED / REMOVED FROM A REGISTER MAINTAINED BY ANY REGISTRATION AUTHORITY WITH WHOM YOU ARE / WERE REGISTERED?** [INCLUDE ANY ERASURE/REMOVAL DUE TO NON-PAYMENT OF FEES.] ☐ YES* ☐ NO

***IMPORTANT: IF YOU ANSWERED "YES" TO Q.8, PLEASE PROVIDE FULL PARTICULARS ON A SEPARATE PAGE AND ANSWER Q.8.A, Q.8.B AND Q.8.C OVERLEAF.**

Q.8.A. NAME, ADDRESS AND CONTACT DETAILS OF THE REGISTRATION AUTHORITY / EMPLOYER:

NAME:

ADDRESS:

CONTACT DETAILS:

Q.8.B. THE NATURE OF THE DISCIPLINARY PROCEEDINGS AGAINST YOU, THE OUTCOME OF THE INQUIRY OR DISCIPLINARY PROCESS AND THE SANCTION IMPOSED, E.G. ERASED / SUSPENDED / FINE IMPOSED / CONDITIONS ATTACHED:

OUTCOME OF THE INQUIRY / DISCIPLINARY PROCESS:

SANCTION IMPOSED:

Q.8.C. IF SANCTIONS / RESTRICTIONS STILL IN PLACE, ON WHAT DATE ARE THEY DUE TO BE REVIEWED / TERMINATED?

PARTICULARS / ADDITIONAL INFORMATION:

IMPORTANT:

IF YOU ANSWERED '**YES**' TO QUESTIONS **3, 4 OR 5** ON THE PREVIOUS PAGE, YOU MUST PROVIDE **FULL PARTICULARS** BELOW, INCLUDING NAME, ADDRESS AND CONTACT DETAILS OF YOUR TREATING DOCTOR(S) (FOR **Q.3 / Q.4**) OR THE BODY WHICH CONDUCTED THE ASSESSMENT (FOR **Q.5**). A FULL STATEMENT SHOULD ALSO BE COMPLETED ON A SEPARATE PAGE AND ATTACHED.

NAME:

ADDRESS:

CONTACT DETAILS:

NAME:

ADDRESS:

CONTACT DETAILS:

PARTICULARS / ADDITIONAL INFORMATION:

9. PROFESSIONAL EXPERIENCE (TO BE COMPLETED BY ALL APPLICANTS)

- PLEASE INDICATE BELOW, IN DATE ORDER, WORKING FORWARD FROM THE DATE YOU GRADUATED TO DATE, HOW AND WHERE YOU HAVE BEEN OCCUPIED SINCE OBTAINING YOUR BASIC (PRIMARY) MEDICAL DEGREE.
- **YOU MUST ALSO INCLUDE ANY PERIODS WHEN YOU WERE NOT ENGAGED IN THE PRACTICE OF MEDICINE.**
- ALL FIELDS MUST BE COMPLETED, I.E. POST HELD, FROM, TO, COUNTRY AND NAME & ADDRESS OF EMPLOYER, FOR EACH PERIOD.
- LEAVING GAPS WILL DELAY THE PROCESSING OF YOUR APPLICATION.

NOTE: CATEGORIES 1, 2 AND 3 APPLICANTS ARE REQUIRED TO PROVIDE DETAILS FOR THE PAST FIVE YEARS ONLY.

IMPORTANT PLEASE READ THE FOLLOWING BEFORE CONTINUING

- IF YOU HAVE NOT BEEN PRACTISING MEDICINE FOR ANY PERIOD GREATER THAN 2 WEEKS OF TIME BETWEEN POSTS, PLEASE STATE THE REASON. FAILURE TO PROVIDE THE REASON FOR THE GAP WILL RESULT IN A DELAY,

POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		

REMINDER CV gaps greater than two weeks will be queried

9. PROFESSIONAL EXPERIENCE (CONTINUED)

POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		

IF YOU NEED MORE SPACE, PLEASE PRINT THIS PAGE AGAIN, COMPLETE AND ATTACH TO THIS FORM.

10. DECLARATION *(THIS DECLARATION MUST BE SIGNED BY ALL APPLICANTS)*

TO: THE CHIEF EXECUTIVE OFFICER, MEDICAL COUNCIL

I HEREBY DECLARE AND NOTE THAT:-

(a)	the information contained in this form and all documentation* provided in support of my application is true and accurate to the best of my knowledge and belief and I have signed this form in my own handwriting;
(b)	I have read and noted carefully the Medical Council's Registration Rules 2011 and the current Guide to the Application Procedure and Registration Rules;
(c)	I have read and understood the current edition of the Medical Council's *Guide to Professional Conduct and Ethics*;
(d)	I undertake to comply with paragraph 50.1 of the Medical Council's *Guide to Professional Conduct and Ethics* (see overleaf) regarding professional indemnity cover;
(e)	I hereby acknowledge and accept that failure by me to enclose all documents required by the Medical Council will result in my application being declared invalid and the Level 1 document examination fee being forfeited;
(f)	I possess the skills to communicate effectively with patients and colleagues in the Republic of Ireland. ***IMPORTANT*** *Under EU freedom of movement legislation, the Medical Council is not entitled to require evidence of English language proficiency from EU citizens. The Medical Council strongly urges that all applicants for whom English is not their first language should attempt the IELTS to ensure that they have sufficient language skills to practise medicine in Ireland. Applicants should note that they may be required by employers or agencies to meet certain English language requirements. Paragraph 12.1 of the Medical Council's Guide to Professional Conduct and Ethics states: "if you do not have the professional* ***or language skills****...you* ***must*** *refer the patient to a colleague who can meet those requirements." It may be considered professional misconduct if a medical practitioner is unable to communicate effectively with their patients and colleagues.* ***See overleaf for examples of evidence of communication skills***.
(g)	I am familiar with the legislation appertaining to the practice of medicine in the Republic of Ireland;
(h)	I am willing to attend the Medical Council's offices to be interviewed in relation to this application, if required;
(i)	I have not been suspended, erased or prohibited from practising medicine, or from being registered as a medical practitioner in any country and, to the best of my knowledge, there is no inquiry or disciplinary proceedings in being or contemplated against me in any country, **unless** otherwise indicated in **Q.8** of Section 8 of this application form;
(j)	I know of no reason why the Medical Council should not grant me registration in the Register of Medical Practitioners in accordance with the provisions of the Medical Practitioners Act 2007, as amended by the Health (Miscellaneous Provisions) Act 2007;
(k)	I acknowledge that the granting of registration is at the discretion of the Medical Council under the provisions of the Medical Practitioners Act 2007 and the Registration Rules 2011;
(l)	I hereby consent and give authority to the Medical Council to make any enquiry with any body or person in pursuance of my application for registration;
(m)	I understand that canvassing of Council Members, training bodies, referees or any other party in relation to my application is prohibited. I acknowledge that canvassing will not assist my application and could be deemed inappropriate. I accept that reports of canvassing will be notified to the Medical Council.
(n)	I have read and understood the statutory provisions under section 41 subsections (1), (2), (3), (4) and (5) and section 55(1) and (3) of the Medical Practitioners Act 2007 overleaf.

***Under current Medical Council policy, if an applicant provides any documentation in support of an application for registration which is later found to be a forgery, the applicant will be refused registration.**

SIGNATURE OF APPLICANT: DATE:

_____ _____

Evidence of effective communication skills which are sufficient for the practice of medicine could include any of the following: (please tick box(es) applicable to you)

- ☐ The applicant obtained their basic medical degree and completed their internship training through English in a country where English is the primary language, e.g. Ireland, UK, Canada, Australia; or
- ☐ The applicant has been awarded a Higher Qualification listed in Appendix A of the Registration Rules which was obtained through English; or
- ☐ The applicant has a current Academic IELTS Certificate with an overall band score of 7.0 and a minimum score of 6.5 in each module, or
- ☐ The applicant has passed another equivalent English language test.
- ☐ If you have other evidence, please specify:

EXTRACTS FROM THE MEDICAL PRACTITIONERS ACT 2007:

Section 41

(1) A person is guilty of an offence if the person-
  (a) contravenes section 37(a) or (b) or 40(2),
  (b) falsely represents to be a registered medical practitioner, or
  (c) being a registered medical practitioner, falsely represents to be registered in a division of the register other than the division in which the person is registered.

(2) A person is guilty of an offence if the person causes or permits another person to make representations about the first-mentioned person that, if made by the first-mentioned person, would be an offence under subsection (1).

(3) A person is guilty of an offence if the person, with intent to deceive, makes with regard to another person any representation that –
  (a) the first-mentioned person knows to be false, and
  (b) if made by the other person would be an offence by the other person under subsection (1).

(4) A person is guilty of an offence if the person makes or causes to be made any false declaration or misrepresentation for the purpose of obtaining registration.

(5) A person guilty of an offence under this section is liable –
  (a) on summary conviction, to a fine not exceeding €5,000 or imprisonment for a term not exceeding 6 months or both,
  (b) on conviction on indictment-
    (i) in the case of a first offence, to a fine not exceeding €130,000 or to imprisonment for a term not exceeding 5 years or both,
    (ii) in the case of any subsequent offence, to a fine not exceeding €320,000 or to imprisonment for a term not exceeding 10 years or both.

Section 55

(1) For the purpose of keeping the register correct, the Council shall from time to time as occasion requires correct all clerical errors in the register, remove therefrom all entries therein procured by fraud or misrepresentation, enter in the register every change which comes to the Council's knowledge in the addresses of the registered medical practitioners, and remove the registration of all registered medical practitioners whose death has been notified to, or comes to the knowledge of, the Council.

...

(3) The Council shall take such steps as it considers necessary from time to time to ensure that the particulars entered in the register are accurate.

EXTRACT FROM THE MEDICAL COUNCIL'S *GUIDE TO PROFESSIONAL CONDUCT AND ETHICS FOR REGISTERED MEDICAL PRACTITIONERS:*

50 Professional Indemnity

50.1 You must ensure that you have adequate professional indemnity cover for all healthcare services you provide.

11. CHECKLISTS

Copies of Documents must be submitted in the *Following* format

- All copy documents must be **notarised** by a Notary Public or attested by a Justice of the Peace/ Commissioner for Oaths/ Member of An Garda Siochána (documents signed by a Police Officer from another country are not acceptable). The Medical Council will not accept notarised/attested copy documents from anyone else.
- They should confirm that the copy is a true copy of the original document, give their full name and sign, date and officially stamp each copy document.
- **All documents which are not in the English language must be attached to an English language translation issued and officially stamped by an official translator**. The name and address of the translator used must be included, to allow for verification.

PLEASE TICK THE APPROPRIATE BOXES TO INDICATE WHICH DOCUMENTS ARE ENCLOSED

Documents for Category 1 Applicants

1(a)	Completed Application Form. [All questions must be answered and the Declaration must be signed.]	
1(b)	Notarised/attested copy of current passport.	
1(c)	An original Certificate of Current Professional Status/Good Standing, dated within the last **3 months**, **to be sent directly** to the Medical Council from all overseas registration authorities with whom you are or have been registered within the past **five years**. [NOTE: If the name on your degree differs to the name on your Certificate, we also require the authority to confirm that you are one and the same person.]	
Fees	**Application Fee (Level 1 assessment)** - This payment must be provided with your application. Please note that it is non-refundable	

Documents for Category 2 and 3 Applicants

2(a)	Completed Application Form. [All questions must be answered and the Declaration must be signed.]		
2(b)	Notarised/attested copy of current passport. (Only pages with your details and the expiry date of passport should be provided)		
2(c)	Notarised/attested copy of basic (primary) medical qualification which was received on the day of conferral, clearly displaying the full date. English translation (If applicable)		
2(d)	Notarised/attested copy Certificate confirming that your qualifications and training are in accordance with Article 24 and Annex V, V.1, 5.1.1. of Directive 2005/36/EC (Conformity letter). [Required from applicants who **began their basic medical training in an EU member state before it joined the EU** - please see Appendix C of the Guide to Registration for the dates each state joined the EU i.e. "**Reference Date**"] English translation (if applicable)		
2(e)	Notarised/attested copy **Certificate to accompany qualification** issued under Directive 2005/36/EC (as amended) including an English translation (if applicable). Please Refer to Appendix C of the Guide to Registration and search for the country where you qualified. If the field under the above heading is blank the Certificate is not required. If a document is listed then that document is required.		
2(f)	An original Certificate of Current Professional Status/Good Standing, dated within the last **3 months**, **to be sent directly** to the Medical Council from all overseas registration authorities with whom you are or have been registered within the past **five years**. [NOTE: If the name on your degree differs to the name on your Certificate, we also require the authority to confirm that you are one and the same person.]		
Fees	**Application Fee (Level 1 assessment)** - This payment must be provided with your application. Please note that it is non-refundable	€410	

Documents for Category 4 Applicants

3(a)	Completed Application Form. [All questions must be answered and the Declaration must be signed.]	
3(b)	Notarised/attested copy of current passport. (Only pages with your details and the expiry date of passport should be provided)	
3(c)	Notarised/attested copy of basic (primary) medical qualification which was received on the day of conferral, clearly displaying the full date. English translation (If applicable)	
3(d)	Notarised/attested copy Internship Certificate or Certificate of Experience or equivalent. [In the case of Pakistan, the document must be from the Pakistan Medical & Dental Council, which certifies internship experience] English translation (If applicable) **If seeking an exemption from the PRES on the basis of an equivalent internship, please refer to the Council's website for a list of overseas internships which are currently recognised for that purpose.**	
3(e)	Documentary evidence of effective communication skills which are sufficient for the practice of medicine (see FAQs on website for further details).	
3(f)	An original Certificate of Current Professional Status/Good Standing, dated within the last **3 months**, **is being sent directly** to the Medical Council from all overseas registration authorities with whom I am or have been registered within the past **five years**. [NOTE: If the name on your degree differs to the name on your Certificate, we also require the authority to confirm that you are one and the same person.]	
3(g)	4 x recent colour passport-size photographs signed on the back by the Applicant.	
3(h)	**If seeking an exemption from the PRES on the basis of a recognised higher qualification:** - Notarised/attested copy evidence of Higher Qualifications (see Appendix I of the Guide to Registration for a list or recognised Higher Qualifications) English translation (If applicable) **AND** - Evidence of an internship of at least twelve months which comprised of a minimum of three months in medicine in general and three months in surgery in general **OR** - have completed a minimum of three years in an accredited training programme – an attestation from the relevant post graduate training body stating the name of the training programme and duration, must be provided.	
Fees	**Application Fee (Level 1 assessment)** - This payment must be provided with your application. Please note that it is non-refundable — €410	

IMPORTANT:
Please note that the application fee is **non-refundable** and a registration fee is payable (if granted) for the remainder of the current registration year. It is Medical Council policy to grant registration on the date the application is complete, unless otherwise requested by the applicant before being registered.

I enclose the above documentation and fees in support of my application for registration, pursuant to the provisions of the Medical Practitioners Act 2007 as amended.

SIGNATURE : _____

DATE: _____

12. **PAYMENT OF FEES**

Please note that the application fee is **non-refundable.** Please consult our website for the most up-to-date information regarding application fees at: https://www.medicalcouncil.ie/registration/fees.asp.

Method of Payments:
Payments may be made to the Medical Council by Cheque / Bank Draft or Credit / Laser Card.

1. By Cheque
Irish Bank cheques are acceptable and must be made out in Euro. Sterling cheques are acceptable and must be made out in Sterling and payable at a British Bank in the U.K. U.S. dollar cheques are acceptable and must be made out in U.S. dollars and payable at an American Bank in the U.S.

2. By Bank Draft
Bank drafts are acceptable provided:
(a) they are in Euro and are **payable at an Irish Bank in Ireland**. (If they are in Euro but payable at a foreign bank these will be returned as they will incur bank charges which may differ from day to day.) OR
(b) they are acceptable in Sterling payable at a British Bank in the U.K. OR
(c) they are acceptable in U.S. dollars payable at an American Bank in the U.S.

3. Credit / Laser Cards
Payments may be made by Visa or Mastercard or by Lasercard by completing the form below.
An additional fee of 2.02% will apply to all VISA and MASTERCARD payments and a fee of €0.25 for all LASERCARD transactions. If you require any assistance regarding the above, please contact the Council's Finance section at +353-1-4983100.

PLEASE COMPLETE THIS FORM IF PAYING BY CREDIT / LASER CARD
(THIS PAGE WILL BE DETACHED AND SENT TO OUR FINANCE SECTION WHEN YOUR COMPLETE APPLICATION IS RECEIVED.)

Doctor's Name: _____

Registration Number (if known): _____

CREDIT CARD NUMBER																	Exp Date	M	M	Y	Y

CVV NO. (last 3 digits on back)				☐ VISA	☐ MASTERCARD

LASERCARD NUMBER																		Exp Date	M	M	Y	Y

Name of card holder: _____

Address of card holder: _____

_____

Signature: _____ Date: _____

AMOUNT TO BE DEBITED:
(An additional fee of 2.02% will apply to all VISA/MASTERCARD payments and €0.25 for all LASER transactions).
REASON FOR PAYMENT: DOCUMENT EXAMINATION FEE (LEVEL 1 ASSESSMENT)

€

Office Use Only:

PLEASE COMPLETE THIS FORM IF YOU WISH TO AUTHORISE THE MEDICAL COUNCIL TO TAKE A FURTHER PAYMENT BY CREDIT / LASER CARD FOR REGISTRATION (IF GRANTED)

Doctor's Name: _____

Registration Number (if known): _____

Credit Card: Visa ☐ Mastercard ☐

CREDIT CARD NUMBER																	Exp Date	M	M	Y	Y

CVV NO. (last 3 digits on back)			

LASERCARD NUMBER																		Exp Date	M	M	Y	Y

Name of card holder: _____

Address of card holder: _____

_____

Signature: _____ Date: _____

AMOUNT TO BE DEBITED:
(An additional fee of 2.02% will apply to all VISA/MASTERCARD payments and €0.25 for all LASER transactions).
REASON FOR PAYMENT: REGISTRATION FEE

€

Office Use Only: