



Maldives Allied Health Council
Ministry of Health , Male', Republic of Maldives

Application for registration of Health Professionals *

- Notice: 1. Please use BLOCK letters in filling this application form
2. Items I to V are to be filled and completed by the applicant.
3. Item VI is to be completed and endorsed by the current employer.
4. Registration at Maldives Board of health Sciences is subject to receipt of all necessary documents in good order.
5. Originals and a copy of each certificate, passport/ID and a recent photograph (not more than 6 months) must be submitted along with this application. All originals will be returned after verification.
6. Registration fee MVR 150 (non-refundable)

New Registration Extension of Registration Practicing License Renewal

Serial No:
Receipt No:

I PERSONAL DETAILS

Name: Sex: F M

Date of Birth: ID Card / Passport No:

Nationality: Contact Tel No :

Permanent Address:

Current Address:
(If different from above)

E- Mail Address: Marital Status :

please paste a recent passport size photograph here

II REGISTRATION DETAILS (if previously registered in Maldives)

Registration Number :

Council / Authority of Registration:

Address:

Registered date : Expiry date :

III QUALIFICATIONS

Professional Qualification	Institute	City / Country	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

IV WORK EXPERIENCE

Organization	City	Country	Positions held	Duration

V DOCUMENTS TO BE SUBMITTED

- Passport (details page)
- National ID card copy
- Qualification certificate
- Mark sheet of the qualification certificate
- Experience certificate (expatriates only)
- Curriculum vitae
- Test results of English language requirement
- Registration at other councils or equivalent body
- Secondary school leaving certificate
- Others

Declaration by Applicant

I declare that the information provided in this form is correct to the best of my knowledge.

Signature: _____

Date : / /

VI CURRENT EMPLOYMENT

Place of Employment in Maldives: _____

Address: _____

Staff No: _____ Position : _____

Date of Employment: / / Contract Valid till: / / Tel No : _____
(for contract staff only)

If Extensions of Registration

I hereby declare that no disciplinary proceedings are in against the above health professional and that he/she has never been subject to any enquiry.

Signature: _____

Date : / /

Declaration by Employer

We confirm the authenticity of the information contained herein about this organization and the applicant's employment status with us.

Name: _____

Signature: _____

Official Stamp

Date : / /

For Official Use

Registration Number at Maldives Allied Health Council : _____

Signature : _____

Date : / /

Designation : _____

*All health and social service professionals registered at MAHC