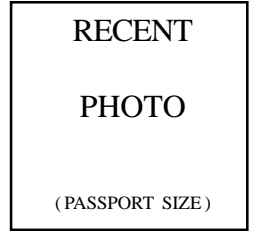


**Application for Registration with the
Maharashtra Medical Council, Mumbai**

Registration No.:
Registration date :

To,
Registrar,
Maharashtra Medical Council
189/A, Anand Complex, 2nd Floor,
Sane Guruji Marg, Arthur Road Naka,
Chinchpokali (W), Mumbai - 400 011.



Sir,
I request you to register my name under the Maharashtra Medical Council Act, 1965 and further to issue certificate of registration to me. My particulars are as follows :

Name of Applicant	:				
		Prefix	(First Name)	(Middle Name)	(Surname)
Name in Devnagari	:				
Name of Father	:				
Name of Mother	:				

In Case of Married Women

Maiden Name	:				
		Prefix	(First Name)	(Middle Name)	(Surname)

Name of Husband :

Name	:				
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PERMANENT ADDRESS : VILLAGE / TOWN _____	TALUKA _____
DISTRICT _____	STATE _____ PIN _____
TELEPHONE (RES) _____	(CLINLC) _____ MOBILE _____

PRESENT ADDRESS FOR COMMUNICATION : _____
PIN _____

RESIDENTIAL ADDRESS IN MAHARASHTRA : _____
(ONLY FOR OTHER STATE CANDIDATE)
attach copy of residential Proof i.e copy of agreement, copy of allotment of govt. Accomodation / Dean / Rector of Med. Collage / Hospital

PURPOSE OF REGISTRATION IN MAHARASHTRA (ATTACH COPY OF PROOF) :
Higher Education <input type="checkbox"/> Private Practice <input type="checkbox"/> Service <input type="checkbox"/>
Attach copy of order _____ Attach copy of order from Employoer _____

Nationality: Indian Other Specify _____ Name of country Sex: Male Female

1. Date of Birth of the Applicant	DD	MM	YYYY
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Name of the qualifying Examination	<input type="checkbox"/> M.B.B.S.	<input type="checkbox"/> Any Other (Specify) : _____
Name of the educational Institution and place from where the applicant completed his course		
Name of the Statutory University and place to which the said Institution is affiliated		
Date of passing the qualifying examination	DD	MM YYYY
1. Name of the instituion in which undergone Internship		
2. Date of starting Internship	DD	MM YYYY
3. Date of Completion in Internship(Original Provisional cert. of MMC to be Attached)	DD	MM YYYY

Specimen Signature of Applicant			
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In case of Applicants registered with another Regulatory Licensing Authority

Name of the Regulatory Authority	:					
State and Nation	:					
Distinctive Number	:		Valid upto :	DD	MM	YYYY
Conditions mentioned on the License (If any)	:					

I have enclosed following certificates in original alongwith their photocopies :

1. Proof of date of birth
2. Certificate of having passed qualifying examination (MBBS) issued by University i.e. M.B.B.S. Degree Certificate.
3. Certificate satisfactory completion of internship issued by the Head of the Institution Annexure I & II and University in original & Attested Xerox copy.
4. Proof of change of name in case of married woman desirous of registration in new name (Registration of marriage certificate / Govt. gazatte / affidavit)
5. Three copies of latest photographs of passport size.
6. N.O.C. in original for other state candidate valid for three month from the date of issue
7. Purpose of Regiatriation in Maharashtra for other state candidate e.g Higher Education/Service/Private Practice attach cpy of proof of concerning authority.
8. Residential Proof in Maharashtra (for other State Candidate). copy of Rent Agreement / Allotment Letter of govt. accomodation / Dean / Rector of Med-College / Hospital
9. Certificate of Registration issued by state council on original and attested xerox copy (for other state candidate)
10. Certificate of Provisional Registration **in original** issued by this Council
11. Demand Draft / Pay Order No. _____ date _____ Rs .2000/- Rs. Two thousand Only
Name of Bank _____ Place of issue _____ favouring
Registrar **Maharashtra Medical Council** payable at **Mumbai**.

DECLARATION

I have carefully read the instructions. I certify that the particulars furnished above are true to the best of my knowledge and belief. I understand that Medical practice without a valid license is not official and lawful. I undertake to inform any change in my postal address due to change in my ordinary place of clinical practice. I read code of medical & Ethics Regulation of Indian Medical Council (Professional Conduct, Etiquette and Ethics Regulation 2002.) I undertake to abide by these Codes in their letter and spirit.

I am aware of legal consequences of misleading the Maharashtra Medical Council.

Date :

Place :

(Signature of the Applicant & Name)

FOR OFFICE USE ONLY

Particular of Payment :	Rs.	<p align="center">Permanent Registration Certificate sent by Speed Post</p> <p>at :</p> <p>.....</p> <p>.....</p> <p>On :</p>
Receipt No. and Date		
Signature of the Clerk		
Name of MMC Clerk		

- Note :
- 1) Instruction sheet attached.
 - 2) Read the instructions carefully before filling the form.
 - 3) Incomplete application form will be rejected.

MAHARASHTRA MEDICAL COUNCIL

Instructions for filling up the Application form for Registration

INSTRUCTIONS

Application needs to be filled in by the applicant in his / her own handwriting. All particulars should be filled in neat legible hand and in block letters ; (i.e., no running hand). No shortforms should be used. The applicant must ensure that the name entered in the application form exactly corresponds with his / her name with us supporting documents.

Name :

- i. In all boxes of names, fill in the name in Roman as well as Devnagari script.
- ii. Prefix : Mention Mr. Ms. Do not write Dr. in any box. The prefix of Mrs. is permitted in the special box provided for Married women applicants. They can retain the prefix of Ms. In that box, if they so desire.
- iii. Devnagari equivalents are as follows : Mr = श्रीमान ; Ms. = श्रीमती ; Mrs. = सौ.
- iv. Married women applying for registration should write their maiden name in the first box. They should indicate their name after marriage in the bold bordered box.

Application may be submitted in person or sent by the registered post / courier on the address mentioned in the application form.

PAYMENT INSTRUCTION

Registration fee of Rs. 2000/- (Rupees Two Thousand only) will be accepted by Demand Draft / Pay Order only, drawn on any Nationalised / Scheduled bank in favour of Registrar, Maharashtra Medical Council, payable at Mumbai.

ACCEPTANCE OF APPLICATION

Duly filled in Application Forms will be accepted Monday to Friday (excluding Holidays) during 10.30 a.m. to 4.00 p.m. of Maharashtra Medical Council. An incomplete form or the one not accompanied with valid payment will not be accepted. No correspondence in this regard will be entertained.

The code of medical Ethics, regulations are available on Medical Council of India website : www.mcindia.org

An prescribed application forms are available on Maharashtra Medical Council website : www.mmcmumbai.com

PRESEVATION

This Certificate of Registration is to be preserved by the Registered Medical Practitioner (RMP) carefully. It is required to be displayed at the normal place of clinical practice.

Registrar



MAHARASHTRA MEDICAL COUNCIL

189 / A, Anand Complex, 2nd Floor, Sane Guruji Marg, Arthur Road Naka, Chinchpokali (W), Mumbai - 400 011.
Website : www.mmcmumbai.com, Tel.2307 2464 / 2308 3043

APPEDIX - 1

DECLARATION

(As per Indian Medical Council { Professional Conduct, Etiquette and Ethics } Regulations 2002)

At the time of registration, each applicant shall be given a copy of the following declaration by the Registrar concerned and the applicant shall read and agree to abide by the same.

1. I solemnly pledge myself to consecrate my life to service of humanity.
2. Even under threat, I will not use my medical knowledge contrary to the laws of humanity.
3. I will maintain the utmost respect for human life from the time of conception.
4. I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
5. I will practice my profession with conscience and dignity.
6. The health of my patient will be my first consideration.
7. I will respect the secrets, which are confined in me.
8. I will give to my teachers the respect and gratitude which is their due.
9. I will maintain by all means in my power, the honour and noble traditions of medical profession.
10. I will treat my colleagues with all respect and dignity.
11. I shall abide by the Code of medical ethics as enunciated in the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002

I make these promises solemnly, freely and upon my honour

I read the above declaration and agree to abide by the same.

Full name : _____

Telephone Number : _____ Mobile Number : _____

Permanent Address : _____

_____ Pin _____

Address in Maharashtra (For other state candidate) : _____

_____ Pin _____

Place : _____

Date : _____

Name & Signature of Applicant