Form MCI-07

MEDICAL COUNCIL OF INDIA

Pocket - 14, Sector - 8, Phase-I, Dwarka, New Delhi - 110 077
Phone : 011-25367033,25367035, 25367036,
Email : mci@bol.net.in, Website : http://www.mciindia.org

APPLICATION FORM FOR GRANT OF TEMPORARY PERMISSION U/S 14(1) TO FOREIGN NATIONAL HOLDING NON-SCHEDULE MEDICAL QUALIFICATION FOR TEACHING, RESEARCH OR PRACTICE MEDICINE IN INDIA AND TEMPORARY REGISTRATION FOR POSTGRADUATE TRAINING (TRAINING PROGRAMS, STUDY PROGRAMS, MODULES AND SHORT TERM COURSE)

(Please read the instructions carefully given in Appendix-I before filling the form.)

Application for Temporary Permission/ Registration:

1.	NAME OF THE APPLICANT (IN BLOCK LETTERS)	
2.	FATHER'S NAME (IN BLOCK LETTERS)	
3.	PRESENT ADDRESS	
4.	PHONE & FAX NO.	
5.	E-MAIL ADDRESS	
6.	DATE AND PLACE OF BIRTH	
7.	NATIONALITY	
8.	NAME OF THE MEDICAL DEGREE/DIPLOMA OBTAINED AND UNIVERSITY/LICENSING BODY WITH THE MONTH AND YEAR OF PASSING THE QUALIFICATION.	

9.	WHETHER PREVIOUSLY VISITED IN INDIA IF SO, DATE, PERIOD AND PLACE OF PREVIOUS	
10.	REGISTRATION PARTICULARS:- (a) ARE YOU REGISTERED IN ANY OTHER FOREIGN COUNTRY? IF SO, GIVE NAME OF THE BODY WITH WHICH REGISTERED AND THE NUMER AND DATE OF REGISTRATION.	
	(b) ARE YOU REGISTERED AS A MEDICAL PRACTITIONER IN YOUR OWN COUNTRY? IF SO GIVE THE NAME OF THE BODY WITH WHICH REGISTERED AND THE NUMBER AND DATE OF REGISTRATION.	
	(c) WHETHER THE REGISTRATION IS RENEWABLE OR PERMANENT.	
	(d) ARE YOU HAVING CURRENT REGISTRATION IN YOUR OWN COUNTRY, IF SO, STATE THE NO. & DATE OF REGISTRATION WITH THE NAME OF THE STATE MEDICAL COUNCIL.	
11.	NAME OF THE MEDICAL COLLEGE/INSTITUTION WHERE THE CANDIDATE IS ALLOWED FOR ADMISSION INTO POSTGRADUATE TRAINING/COURSE/PROGRAMME	
12.	NAME OF THE POSTGRADUATE TRAINING COURSE/PROGRAAME	
13.	PROPOSED DATE OF POSTGRADUATE TRAINING COURSE/PROGRAMME AND NAME OF FACULTY UNDER WHICH PROPOSED TRAINING COURSE/ PROGRAMME IS TO BE DONE.	
14.	NAME OF THE SPONSORING HOSPITAL/INSTITUTE WITH COMPLETE ADDRESS.	
15.	PROPOSED DATE OF TRAINING/ RESEARECH/PRACTICE MEDICINE	

	NAME OF THE PERSON IN THE SPONSORING INSTITUTION/HOSPITAL WHO WILL BERESPONSIBLE FOR THE LEGAL ISSUES REGARDING THE PATIENT CARE PROVIDED BY THE ABOVE SAID FOREIGN DOCTOR.	
16.	NATURE OF EMPLOYMENT IN MEDICAL COLLEGE/ HOSPITAL OR MEDICAL INSTITUTION IN INDIA.	
17.	IS THE EMPLOYMENT TEMPORARY OR PERMANENT OR FOR A LIMITED PERIOD.	
18.	DETAILS OF PAYMENT OF FEES: AMOUNT IN INR: DETAILS OF DEMAND DRAFT (a) NAME & ADDRESS OF ISSUING BANK (b) DEMAND DRAFT NO. ___ (c) Date:	

SIGNATURE OF THE HEAD OF THE SPONSORING INSTITUTE/HOSPITAL WITH STAMP

SIGNATURE OF THE APPLICANT

DATE: _____

PLACE: _____

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APPENDIX-I
INSTRUCTIONS

1. THE APPLICATION FORM SHOULD BE PROPERLY AND NEATLY FILLED IN BY THE APPLICANT AND SHOULD BE SUBMITTED ALONG WITH THE FOLLOWING DOCUMENTS IN 5 (FIVE) SETS: -

   a) COPY OF PROVISIONAL DEGREE OR DIPLOMA OR CERTIFICATE HAVING PASSED THE MEDICAL EXAMINATION ISSUED BY THE DEAN OF THE COLLEGE /UNIVERSITY. IF THE DEGREE/DIPLOMA OR CERTIFICATES ARE IN ANY OTHER REGIONAL LANGUAGES A TRUE COPY OF THE SAME AS WELL AS AUTHENTIC ENGLISH TRANSLATION.(This is applicable only for foreign students who have been selected for Postgraduate Training Course in a Medical College/Institute in India).

   b) COPY OF CURRENT REGISTRATION CERTIFICATE IN YOUR OWN COUNTRY DULY ATTESTED.

   c) A CERTIFICATE FROM THE HEAD OF THE INSTITUTION UNDER WHICH THE CANDIDATE IS EMPLOYED / TO BE EMPLOYED TO THE EFFECT THAT SERVICES RENDERED BY THE FOREIGNER ARE FOR THE PURPOSE OF TEACHING, RESEARCH OR PRACTICE MEDICINE IN INDIA AND NOT FOR PERSONAL GAIN.

   d) COPY OF PASSPORTDULY SELF ATTESTED.

   e) COPIES OF ALL DEGREE/DIPLOMA DULY SELF VERIFIED.

   f) SPONSORSHIP LETTER FROM THE INSTITUTE/HOSPITAL IN INDIA.

   g) NON REFUNDABLE APPLICATION FEE OF RS. 5000/- (RUPEES FIVE THOUSAND ONLY) BY A BANK DRAFT IN FAVOUR OF “THE SECRETARY, MEDICAL COUNCIL OF INDIA”, PAYABLE AT NEW DELHI. ON REVERSE OF THE DRAFT, FOLLOWING DETAILS TO BE FILLED BY THE APPLICANT AND DULY SIGNED: -

      (i) Name

      (ii) Father’s Name

      (iii) Purpose for which the draft submitted

      (iv) Telephone No with Code/Mobile No.

2. **AS PER THE INSTRUCTION OF THE GOVT. OF INDIA, MINISTRY OF HEALTH AND FAMILY WELF ARE, THE PROPOSAL ALONGWITH THE RECOMMENDATION OF THE MCI MUST BE RECEIVED BY IT ATLEAST ONE MONTH BEFORE THE SCHEDULED DATES OF THE PROPOSED TRAINING /PRACTICE IN INDIA. THEREFORE APPLICANT AND SPONSORING AUTHORITY MUST ENSURE THAT THE APPLICATION MUST BE RECEIVED BY THE COUNCIL AT LEAST TWO MONTHS BEFORE THE SCHEDULED DATE OF COMMENCEMENT OF TRAINING/PRACTICE IN INDIA FAILING WHICH THE APPLICATION MAY BE LIABLE TO BE REJECTED BY THE CENTRAL GOVT./MCI.**

3. **APPLICATION FOR TEMPORARY PERMISSION FOR FOREIGN NATIONALS FOR TRAINING/PRACTICE IN INDIA MUST BE RECEIVED THROUGH THE SPONSORING HOSPITAL/INSTITUTE ALONGWITH ALL DOCUMENTS AS MENTIONED ABOVE. NO DIRECT APPLICATION FROM THE FOREIGN NATIONALS WILL BE ENTERTAIED.**

4. APPLICANT IS ADVISED TO RETAIN COPY OF HIS/HER APPLICATION AND DRAFT FOR FUTURE REFERENCE.

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CHECK LIST for submission of documents

THE CANDIDATES ARE REQUESTED TO ENSURE THAT THE DOCUMENTS BE ENCLOSED AS PER THE ORDER IN THE CHECKLIST. ALL PAPERS/DOCUMENTS SHOULD BE NUMBERED ACCORDING TO THE CHECKLIST. PLEASE ARRANGE THE APPLICATION IN THE FOLLOWING ORDER & TICK MARK THE RELEVANT BOXES:

1.	Bank Draft: ……..	Yes	No
2.	Application form …….	Yes	No
3.	Copies of degree or diploma or certificate: …….	Yes	No
4.	Certificate of permanent Registration ……	Yes	No
5.	Sponsorship letter from the sponsoring authority:…….	Yes	No
6.	Copy of passport …….	Yes	No
7.	Admission letter from the college/hospital where the training Is to be scheduled……...	Yes	No

Signature _____

Dated _____

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ACKNOWLEDGEMENT

(to be filled by the candidate)

Received Application from Ms/ Mr.……

D/o / S/o Sh.…….. alongwith Bank Draft/DD

No…… dated..…….. for Rs……..

Drawn on Bank.……

for issuance of Temporary Registration/Permission.

OFFICIAL SEAL

Signature of Receiving Official
with date