MIZORAM STATE MEDICAL COUNCIL

Government of Mizoram, Health & Family Welfare Department

APPLICATION FOR MEMBERSHIP REGISTRATION

Passport Photo

1. PERSONAL INFORMATION

FULL NAME (AS PER MEDICAL DEGREE CERTIFICATE)

EMAIL ADDRESS

MOBILE NUMBER

DATE OF BIRTH (DD/MM/YYYY)

GENDER

☐ Male
☐ Female
☐ Other

QUALIFICATION

RESIDENTIAL ADDRESS

2. QUALIFICATIONS & SPECIALIZATIONS

PRIMARY MEDICAL DEGREE

UNIVERSITY / INSTITUTION

YEAR OF GRADUATION

REGISTRATION NO. (IF ANY)

SPECIALIZATIONS (IF APPLICABLE — ATTACH ADDITIONAL DOCUMENTS FOR EACH)

#	SPECIALIZATION NAME	CERTIFICATE / DOCUMENT ATTACHED
1.		
2.		
3.		

3. DOCUMENTS TO BE ATTACHED

☐ Recent passport-size photograph (coloured, white background)

☐ Copy of MBBS / MD / MS Degree Certificate

☐ Specialization certificate(s) (one per specialization listed above)

I hereby declare that the information furnished in this application is true, complete, and correct to the best of my knowledge and belief. I understand that any misrepresentation or suppression of facts may lead to rejection of this application or cancellation of membership, if already granted. I agree to abide by the rules, regulations, and by-laws of the Mizoram State Medical Council.

Date (DD/MM/YYYY)

Signature of Applicant

FOR OFFICE USE ONLY

APPLICATION NO.

RECEIVED DATE

REVIEWED BY

STATUS

☐ Approved
☐ Rejected
☐ Pending

REMARKS