SURNAME: ----------
(In Block Letters)

NAME: ----------
(In Block Letters)

DATE OF BIRTH: ----------

MAILING ADDRESS: ----------
(In Block Letters)

EMAIL ADDRESS: ----------

TEL No: HOME:----------**MOBILE:** ----------

REGISTERED WITH THE MEDICAL COUNIL OF MAURITIUS AS:

☐ **General Practitioner:** ☐ **Specialist:**

FIELD OF SPECIALITY (applicable to Specialists): ----------

PRESENT EMPLOYMENT:

☐ **Public Sector** ☐ **Private Sector**

ADDRESS OF PRESENT EMPLOYMENT: ----------
(In Block Letters)

NOTE: <u>Form to be submitted within 2 weeks</u>