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***MEDICAL COUNCIL OF MAURITIUS***

**Continuing Professional Development**

**Application form for approval of CPD Event**

Name of CPD Provider: -----------------------------------------------------------------------------------

Title of CPD Event: -----------------------------------------------------------------------------------

Name of Speaker: -----------------------------------------------------------------------------------

GP/SP: --------------- Field of specialisation: ------------------------------------------------------------------

Duration: from -------------- hrs to ------------------ hrs

Date of CPD Event: --------------------------------

Venue: -----------------------------------------------------------------------------------

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Number of seats available: ---------------

Target Audience: -----------------------------------------------

Open/On Invitation: -----------------------------

Biodata of Speaker enclosed: Yes No Already submitted:

Abstract of CPD event enclosed: Yes No

Signature of CPD Provider: ------------------------------------------------------------

Date: --------------------------------

***(Kindly note that approval for CPD event must be submitted at least 4 weeks prior to the event and that there should be a minimum of 10 attendees for CPD events)***