

**UGANDA MEDICAL & DENTAL PRACTITIONERS COUNCIL**  
**P.O. Box 16115, TEL/FAX: 256-41-345844, KAMPALA,**

**THE REQUIREMENTS FOR REGISTRATION OF ALL FOREIGN TRAINED  
MEDICAL DOCTORS /DENTISTS**

The following documents are required for verification purposes. In the absence of original copies, copies certified by a Notary or by academic/professional institutions are acceptable.

1. University Degree/Professional Medical Qualification Certificates
2. Academic Transcripts -
3. Evidence of completion of Internship
4. Current Certificate of Registration in Country of Origin
5. Certificate of Good Standing

**In addition, the following documents and information are required:**

6. Curriculum Vitae
7. References from three (3) Professional Associates
8. Evidence confirming Intended Employer/Place of work
9. For Specialists: - Evidence -of Postgraduate Training of not less than three (3) years; and Evidence of active practice in area of Specialty for the past five (5) years. -
10. Two (2) recent Pi sport size Photographs
11. Duly filled-in application forms

Once your application has been processed and approved, a Registration fee must be paid before a Certificate is issued. The amount will depend on the duration of stay while practicing medicine in Uganda.

All documents written in a language other than English must be accompanied by a copy of an official translation of the document, which is duly certified by a Notary.

Applicants are advised to submit the duly filled-in forms and accompanying documents at least three (3) months in advance, in order to allow for timely processing of the request.

**UGANDA MEDICAL AND DENTAL PRACTITIONERS COUNCIL  
LICENCING OF MEDICAL AND DENTAL PRACTITIONERS  
Fees Structure w.e.t. 1<sup>st</sup> January 2010**

	FEE CATEGORY	REGISTRATION STATUS	FREQUENCY OF PAYMENT	AMOUNT
1	PROVISIONAL REGISTRATION	Intern - Ugandans	ONCE	
2	PROVISIONAL REGISTRATION	Ugandans Intern - Non-Ugandans	ONCE	
3	FULL REGISTRATION	Ugandans with EAC qualifications	ONCE	
4	FULL REGISTRATION	Ugandans with non-EAC qualifications	ONCE	
5	SPECIALIST REGISTRATION	Post-graduate M. Med or equivalent (Minimum 3 yrs post-graduate training)	ON REQUEST	
6	ADDITIONAL QUALIFICATION	Post. basic higher qualification (Less than 3 yrs post -graduate training)	ON REQUEST	
7	PRACTICING LICENCE	All registered practitioners (CPD certification requirement)	ANNUAL	
8	CERTIFICATE OF GOOD STANDING	All categories	ON REQUEST	
9	CERTIFICATE OF GOOD TEMPORARY REGISTRATION	Non-Ugandan practitioners in Public Service NGO health unit	ON REQUEST	
10	RENEWAL OF TEMPORARY REGISTRATION	Non-Ugandan practitioners in Public Service/NGO health unit	ON REQUEST	
11	TEMPORARY REGISTRATION	Non-Ugandan practitioners in Private health unit	ON REQUEST	
12	RENEWAL OF TEMPORARY REGISTRATION	Non-Ugandan practitioners in Private health unit	ON REQUEST	

Maximum period for Temporary Registration is 2 years EAC (East African Community)

Issued by the Registrar  
Uganda Medical and Dental Practitioners Council

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Fees Structure w.e.t. 1<sup>st</sup> January 2010**

**APPLICATION FORM**

**1. INFORMATION ABOUT PPPLICANT**

1. Surname.....
2. First name.....
3. Telephone No..... Fax.....  
E-mail.....
4. Nationality.....
5. Sex.....
6. Date, Month and Year of birth.....
7. Marital Status (single /married/divorced/widowed) (tick)
8. Current employer:.....
9. Present Permanent Postal address:  
.....  
.....  
.....
10. Understanding of spoken/written English: (tick one)
  - Excellent
  - Good
  - Fair
  - None
11. Other language

- Note: (I) Attach two clear passport size own latest photographs
- (II) In case of married female doctors who are using husband's Names attach certified /Notarised copies of Marriage Certificate.
- (III) Attach detailed curriculum vitae.

**II. REASONS. FOR APPL1CA1ION**

12. Category of Registration applied for: (tick one)

- Provisional registration
- Full registration
- Specialist registration.
- Temporary registration (for non-Ugandans).

13. Purpose .....

.....

14. Employment commencing on.....

.....

15. Intended Employer.....

16. Postal Address of Employer.....

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17. Employer.....

Telephone No.....

Fax.....

E-Mail.....

**III. UNIVERSITY EDUCATION**

19. Universities attended for medical or dental education

<b>COUNTRY</b>	<b>UNIVERSITY</b>	<b>WARD TITLE</b>	<b>DURATION OF TRAINING</b>	<b>YEAR OF AWARD</b>

20. Field of specialization, if any .....

Note: Certified/Notarised copies of above award, Academic transcripts and Course content Should be attached.

21. Internship training

<b>COUNTRY</b>	<b>HOSPITAL</b>	<b>FIELD</b>	<b>DURATION</b>

Note: Attach evidence that internship was done.

22. Are you a registered medical/dental practitioner?

Yes

No

**Note:** Attach Certified /Notarised copy of your current registration Certificate with the Council, Board or equivalent medical / dental Regulatory body of a country where you are currently practicing or where you have been practicing previously In the immediate past years.'

**IV. EMPLOYMENT RECORD**

Evidence of practice for the last five years.

Name of Employer	Duration (From ___ to ___)	Nature of practice

23. Do you have a certificate of Good Standing in medical or dental practice issued by a Council, Board of equivalent medical / dental regulatory body of the country where you are currently practicing or where you have been practicing in the immediate past years? Yes No



**Note:** Attach a copy of a certificate of Good Standing.

**V. DECLARATION**

I, the undersigned do hereby certify that under the Medical and Dental Practitioner & Statute of 196 of the Laws of Uganda, the responses given by me to all the above questions, are true, and correct.

.....  
Name

.....  
Signature

.....  
Date

**FOR OFFICIAL USE ONLY**

**Decision taken:**

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**Reason if not accepted**

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.....  
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DATE:.....

REGISTRAR .....