MALDIVIAN MEDICAL ASSOCIATION

Updated Information For Members' Registry

Please fill in with Capitals or Tick where appropriate

PERSONAL DETAILS:		**Executive Member:** ☐ **Associate Member:** ☐
Name: Dr.		Affix a recent Passport Photo
National ID / Passport No (If Expatriates):		
DOB:	**MMC Registration No:**	
Main Appointment:		
Specialty:		

MEDICAL QUALIFICATIONS:

Qualification	Year of Completion	Institute	Country

CONTACT DETAILS	
Permanent Address:	
Residential Address:	**Phone No:**
Place of work:	**Phone No:**
Mobile:	**Primary Email ID:**
Others:	**Preferred Mode of Contact:** Phone call ☐ SMS ☐ Email ☐

OTHERS:
SPECIAL MEDICAL INTEREST:
SPECIAL TALENTS:

DECLARATION:	
All the information provided herein is accurate to the best of my knowledge.	
Date:	**Signature:**

OFFICE USE	**Form Received by:**
	Date: