بسم الله الرحمن الرحيم

MALDIVIAN MEDICAL ASSOCIATION

Membership Application Form

Please fill in with Capitals or Tick where appropriate

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

QUALIFICATIONS:			
Qualification	**Year of Completion**	**Institute**	**Country**

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

DECLARATION:	
All the information provided herein is accurate to the best of my knowledge and I hereby agree to abide by Maldivian Medical Association's article of association	
Date:	**Signature:**

OFFICE USE
Membership Category: Executive Member ☐ Associate Member ☐
Reference No: