RESTOREAPP OFFICE USE ONLY: REFERENCE NUMBER: ☐☐☐☐☐☐

☐ INELIGIBLE ☐ Cat1 ☐ Cat 2 ☐ Cat 3 ☐ Cat 4 ☐ Cat A ☐ Cat B ☐ Cat C ☐ Cat D ☐ Cat E

☐ TSD/IR ☐ TSD/TSR ☐ GD/GR ☐ SD/SR

Comhairle na nDochtúirí Leighis
Medical Council

Kingram House, Kingram Place, Dublin 2.
Telephone: +353-1-4983100
Facsimile: +353-1-4983102
Email: registration@mcirl.ie
Website: www.medicalcouncil.ie

APPLICATION FORM TO RESTORE A MEDICAL PRACTITIONER'S NAME TO THE REGISTER OF MEDICAL PRACTITIONERS UNDER THE PROVISIONS OF THE MEDICAL PRACTITIONERS ACT 2007

ALL 10 PARTS OF THIS APPLICATION FORM MUST BE COMPLETED INCLUDING THE CHECKLIST(S)

1. WHICH CATEGORY?

PLEASE TICK THE MOST APPROPRIATE CATEGORY FOR YOUR APPLICATION BELOW:

	CATEGORY 1: Graduate of Medical School in Ireland (UCD, UCC, NUIG, TCD, RCSI or UL). **Please see website for current fees.**
	CATEGORY 2: EU/EEA or Swiss citizen qualified in an EU/EEA member state or in Switzerland. P**lease see website for current fees.**
	CATEGORY 3: Non-EU citizen who qualified in an EU/EEA member state or in Switzerland. **Please see website for current fees.**
	CATEGORY 4: Graduate of a medical school in a third country (outside EU/EEA/ Switzerland) and qualification listed in WHO/IMED and holds full registration in another country (other than Ireland). **Please see website for current fees.**

Please affix firmly a recent passport-size colour photograph of yourself HERE

NOTE: THE REGISTRATION YEAR RUNS FROM 1ST JULY TO 30TH JUNE EACH YEAR. IF A DOCTOR IS REGISTERED DURING THE REGISTRATION YEAR, A RETENTION FEE IS PAYABLE ON THE FOLLOWING 1ST JULY. [PLEASE SEE IMPORTANT NOTE ON PAGE 18.]
+NOTE: IF REGISTRATION IS GRANTED, ITEMS MARKED + WILL APPEAR ON THE REGISTER OF MEDICAL PRACTITIONERS.
°NOTE: IF REGISTRATION IS GRANTED, ITEMS MARKED ° MAY BE SHARED WITH RELEVANT THIRD PARTIES, EG TRAINING BODIES/ HSE

2. WHICH DIVISION?

PLEASE STATE TYPE OF REGISTRATION PREVIOUSLY HELD: (Please tick appropriate box/es)

☐ Internship ☐ Trainee Specialist ☐ Specialist ☐ General

+° REGISTRATION / REFERENCE NUMBER QUOTED TO YOU IN PREVIOUS CORRESPONDENCE:

☐☐☐☐☐☐☐☐☐☐

ARE YOU SEEKING REGISTRATION IN TRAINING POSTS?

☐ Yes ☐ No (Please tick appropriate box)

IF YES, PLEASE ENSURE YOU COMPLETE SECTION 4 OF THE APPLICATION FORM. IF YOU ANSWER "NO" AND YOU HAVE NEVER BEEN REGISTERED IN THE SPECIALIST DIVISION OF THE REGISTER BEFORE, YOUR APPLICATION WILL BE CONSIDERED TO RESTORE YOUR NAME TO THE GENERAL DIVISION OF THE REGISTER, BUT YOU CAN APPLY FOR SPECIALIST REGISTRATION ONCE YOUR NAME HAS BEEN RESTORED TO THE REGISTER.

HAVE YOU BEEN OFFERED A PLACE/ACCEPTED ON A POSTGRADUATE TRAINING PROGRAMME?

☐ Yes ☐ No (Please tick appropriate box)

3. PERSONAL DETAILS

+°TITLE: (please circle/ tick appropriate box) Professor Dr Mr Ms

PLEASE TICK THE APPROPRIATE BOX BELOW TO INDICATE WHICH SURNAME YOU WISH TO HAVE ENTERED ON THE REGISTER:

+°SURNAME ON YOUR DEGREE/DIPLOMA:

☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

+°CURRENT SURNAME IF DIFFERENT TO ABOVE:

☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

***NOTE**: IF YOUR SURNAME IS DIFFERENT TO THE SURNAME WHICH APPEARS ON YOUR DEGREE/DIPLOMA (E.G. BY MARRIAGE) YOU MUST SUBMIT A NOTARISED/ATTESTED COPY OF YOUR STATE MARRIAGE CERTIFICATE OR DEED POLL. DOCTORS MUST PRACTISE IN THE NAMES IN WHICH THEY ARE REGISTERED - SEE PARAGRAPH 55 OF THE CURRENT GUIDE TO PROFESSIONAL CONDUCT AND ETHICS.*

PLEASE ANSWER ALL QUESTIONS.
IF A QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "NOT APPLICABLE" IN THE SPACE PROVIDED.

+°FORENAMES ON YOUR DEGREE/DIPLOMA: (one per line)

1																				
2																				
3																				
4																				

+°**GENDER:** (please circle/tick appropriate box) Male | Female

°**DATE OF BIRTH:** D D M M Y Y Y Y

MOTHER'S MAIDEN SURNAME (I.E. HER BIRTH SURNAME, E.G. "SMITH"):

NOTE: IN ORDER TO VERIFY YOUR IDENTITY, YOU MAY BE ASKED FOR THE ABOVE INFORMATION WHEN YOU CONTACT THE MEDICAL COUNCIL.

+°ADDRESS TO BE USED FOR ENTRY IN THE REGISTER TO WHICH ALL CORRESPONDENCE WILL BE SENT. [THE MEDICAL COUNCIL MUST BE ABLE TO CONTACT YOU AT THIS ADDRESS WHEN NECESSARY]:

Line 1: _____

Line 2: _____

Line 3: _____

Line 4: _____

City/State/County/Country: _____

***NOTE**: A DOCTOR'S REGISTERED NAME, ADDRESS AND QUALIFICATIONS ARE AVAILABLE TO THE PUBLIC AND ARE PUBLISHED ON OUR WEBSITE. THE COUNCIL IS OBLIGED BY LAW TO PUBLISH THE REGISTERS IT MAINTAINS AND A DOCTOR'S REGISTERED ADDRESS IS PART OF THE REGISTER. HOWEVER A DOCTOR MAY ENTER ANY ADDRESS AT WHICH HE/SHE CAN BE CONTACTED BY THE COUNCIL. IT DOES NOT HAVE TO BE THEIR HOME ADDRESS. THE COUNCIL RECOMMENDS THAT DOCTORS ENTER THEIR PRACTICE ADDRESS AS THEIR REGISTERED ADDRESS.*

IF PREVIOUSLY REGISTERED, PLEASE ENTER YOUR LAST REGISTERED ADDRESS:

_____

_____

°**CONTACT DETAILS:** (PLEASE INCLUDE INTERNATIONAL CODES IF OUTSIDE THE REPUBLIC OF IRELAND)

Phone:																				
Fax:																				
Mobile:																				
E-mail address:	*Contacting applicants about their application by email is often quicker than by post.*																			

4. POSTGRADUATE SPECIALIST TRAINING

ARE YOU REGISTERED WITH A POSTGRADUATE TRAINING BODY IN IRELAND?

☐ Yes ☐ No (Please tick appropriate box)

IF YES, PLEASE PROVIDE NAME AND ADDRESS OF THE TRAINING BODY:

_____

_____

YOUR REFERENCE NUMBER WITH THE TRAINING BODY: | | | | | | | | | | | | |

PLEASE ANSWER ALL QUESTIONS.
IF A QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "NOT APPLICABLE" IN THE SPACE PROVIDED.

5. REGISTRATION DETAILS

PLEASE LIST ALL THE AUTHORITIES WITH WHICH YOU HAVE EVER BEEN REGISTERED FOR THE PURPOSE OF ENGAGING IN THE PRACTICE OF MEDICINE AS A REGISTERED MEDICAL PRACTITIONER:

AUTHORITY #1. NAME AND ADDRESS OF REGISTRATION AUTHORITY:
Name:

Address:

REGISTERED FROM D D M M Y Y Y Y To: D D M M Y Y Y Y

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

AUTHORITY #2. NAME AND ADDRESS OF REGISTRATION AUTHORITY:
Name:

Address:

REGISTERED FROM D D M M Y Y Y Y To: D D M M Y Y Y Y

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

AUTHORITY #3. NAME AND ADDRESS OF REGISTRATION AUTHORITY:
Name:

Address:

REGISTERED FROM D D M M Y Y Y Y To: D D M M Y Y Y Y

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

NOTE: IF REGISTERED WITH ANY ADDITIONAL AUTHORITIES, PLEASE CONTINUE ON A SEPARATE PAGE AND ATTACH.

PLEASE ANSWER ALL QUESTIONS.
IF A QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "NOT APPLICABLE" IN THE SPACE PROVIDED.

PLEASE LIST ANY OTHER HEALTH RELATED AUTHORITIES WITH WHICH YOU HAVE EVER BEEN REGISTERED (EG PHARMACEUTICAL SOCIETIES, PHYSIOTHERAPISTS, ETC):

NAME AND ADDRESS OF AUTHORITY:
Name:

Address:

REGISTERED FROM | D | D | M | M | Y | Y | Y | Y | TO: | D | D | M | M | Y | Y | Y | Y |

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

NAME AND ADDRESS OF AUTHORITY:
Name:

Address:

REGISTERED FROM | D | D | M | M | Y | Y | Y | Y | TO: | D | D | M | M | Y | Y | Y | Y |

TYPE OF REGISTRATION HELD: **REGISTRATION NUMBER:**

NOTE: IF REGISTERED WITH ANY ADDITIONAL HEALTH-RELATED AUTHORITIES, PLEASE CONTINUE ON A SEPARATE PAGE AND ATTACH.

6. IMPORTANT QUESTIONS

NOTE: IT IS IMPERATIVE THAT YOU ANSWER EACH OF THE FOLLOWING 8 QUESTIONS BY TICKING THE APPROPRIATE BOX.

Q.1 HAVE YOU EVER BEEN CONVICTED IN A COURT OF LAW? (INCLUDING A DRUNKEN DRIVING CHARGE) ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS OF YOUR CONVICTION ON A SEPARATE PAGE AND ATTACH.

Q.2 HAVE YOU EVER BEEN DECLARED BANKRUPT OR HAD A CHARGE/JUDGMENT MADE AGAINST YOU? ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS ON A SEPARATE PAGE AND ATTACH.

Q.3 DO YOU NOW OR HAVE YOU EVER SUFFERED FROM A RELEVANT MEDICAL DISABILITY THAT MIGHT AFFECT YOUR COMPETENCE AS A MEDICAL PRACTITIONER? [SEE PARAGRAPH 11 OF THE GUIDE TO REGISTRATION.] ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS, INCLUDING NAME, ADDRESS AND CONTACT DETAILS OF YOUR TREATING DOCTOR(S) IN THE SPACE PROVIDED ON PAGE 8 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.4 HAVE YOU EVER BEEN TREATED FOR:

(A) ALCOHOL DEPENDENCE? ☐ YES* ☐ NO

(B) DRUG DEPENDENCE? ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS, INCLUDING NAME, ADDRESS AND CONTACT DETAILS OF YOUR TREATING DOCTOR(S) IN THE SPACE PROVIDED ON PAGE 8 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

PLEASE ANSWER ALL QUESTIONS.
IF A QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "NOT APPLICABLE" IN THE SPACE PROVIDED.

Q.5 HAVE YOU EVER BEEN REQUIRED TO UNDERGO REMEDIATION/RETRAINING FOLLOWING AN ASSESSMENT OF YOUR COMPETENCE/PERFORMANCE AS A MEDICAL PRACTITIONER BY A REGISTRATION AUTHORITY OR OTHER BODY RESPONSIBLE FOR CONDUCTING SUCH ASSESSMENTS? ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS, INCLUDING THE NAME OF THE BODY WHICH CONDUCTED THE ASSESSMENT IN THE SPACE PROVIDED ON PAGE 8 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.6 HAS ANY REGISTRATION AUTHORITY EVER REFUSED TO GRANT YOU REGISTRATION TO ENGAGE IN THE PRACTICE OF MEDICINE AS A REGISTERED MEDICAL PRACTITIONER? ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS, INCLUDING THE REASONS FOR REFUSAL, IN A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.7 HAVE YOU EVER BEEN DEPORTED AND/OR EXCLUDED FROM ANY COUNTRY? ☐ YES* ☐ NO

*IF **YES**, PLEASE PROVIDE FULL PARTICULARS IN A STATEMENT ON A SEPARATE PAGE AND ATTACH.

Q.8 HAVE YOU EVER BEEN THE SUBJECT OF DISCIPLINARY PROCEEDINGS OR A COMPLAINT OR ARE ANY PROCEEDINGS OR COMPLAINTS IN PROGRESS OR PENDING NOW BY AN AUTHORITY WITH WHOM YOU ARE OR WERE REGISTERED OR EMPLOYED AS A MEDICAL PRACTITIONER? AND/OR HAS YOUR NAME EVER BEEN ERASED/SUSPENDED/REMOVED FROM A REGISTER MAINTAINED BY ANY REGISTRATION AUTHORITY WITH WHOM YOU ARE/WERE REGISTERED? ☐ YES* ☐ NO
[INCLUDE ANY ERASURE/REMOVAL DUE TO NON-PAYMENT OF FEES.]

***IMPORTANT: IF YOU ANSWERED "YES" TO Q.8, PLEASE PROVIDE FULL PARTICULARS AND ANSWER Q.8.A, Q.8.B AND Q.8.C OVERLEAF.**

Q.8.A. NAME, ADDRESS AND CONTACT DETAILS OF THE REGISTRATION AUTHORITY/EMPLOYER:

NAME:

ADDRESS:

CONTACT DETAILS:

Q.8.B. THE NATURE OF THE DISCIPLINARY PROCEEDINGS AGAINST YOU, THE OUTCOME OF THE INQUIRY OR DISCIPLINARY PROCESS AND THE SANCTION IMPOSED, E.G. ERASED/SUSPENDED/FINE IMPOSED/ CONDITIONS ATTACHED:

NATURE OF THE COMPLAINT:

OUTCOME OF THE INQUIRY / DISCIPLINARY PROCESS:

SANCTION IMPOSED:

PLEASE ANSWER ALL QUESTIONS.
IF A QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "NOT APPLICABLE" IN THE SPACE PROVIDED.

Q.8.C. ARE THESE SANCTIONS/RESTRICTIONS STILL IN PLACE? ☐ YES ☐ NO

IF YES, ON WHAT DATE ARE THEY DUE TO BE REVIEWED/TERMINATED? D D M M Y Y Y Y

IMPORTANT:

IF YOU ANSWERED '**YES**' TO QUESTIONS **3, 4 OR 5** ON THE PREVIOUS PAGE, YOU MUST PROVIDE **FULL PARTICULARS** BELOW, INCLUDING NAME, ADDRESS AND CONTACT DETAILS OF YOUR TREATING DOCTOR(S) (FOR **Q.3/Q.4**) OR THE BODY WHICH CONDUCTED THE ASSESSMENT (FOR **Q.5**). A FULL STATEMENT SHOULD ALSO BE COMPLETED ON A SEPARATE PAGE AND ATTACHED.

NAME: NAME:

ADDRESS: ADDRESS:

CONTACT DETAILS: CONTACT DETAILS:

PARTICULARS / ADDITIONAL INFORMATION:

7. PROFESSIONAL EXPERIENCE (TO BE COMPLETED BY ALL APPLICANTS)

PLEASE INDICATE BELOW, IN DATE ORDER, WORKING FORWARD, HOW AND WHERE YOU HAVE BEEN OCCUPIED IN THE PAST FIVE YEARS. YOU MUST ALSO INCLUDE ANY PERIODS WHEN YOU WERE NOT ENGAGED IN THE PRACTICE OF MEDICINE. ALL FIELDS MUST BE COMPLETED, I.E. POST HELD, FROM, TO, COUNTRY AND NAME & ADDRESS OF EMPLOYER, FOR EACH PERIOD. LEAVING GAPS WILL DELAY THE PROCESSING OF YOUR APPLICATION.

POST HELD (INCLUDING SPECIALTY):		COUNTRY:	NAME & ADDRESS OF EMPLOYER:
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		

7. PROFESSIONAL EXPERIENCE (CONTINUED)

POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		
POST HELD (INCLUDING SPECIALTY):		**COUNTRY:**	**NAME & ADDRESS OF EMPLOYER:**
FROM: D D M M Y Y	TO: D D M M Y Y		

IF YOU NEED MORE SPACE, PLEASE PRINT THIS PAGE AGAIN, COMPLETE AND ATTACH TO THIS FORM.

8. DECLARATION *(THIS DECLARATION MUST BE SIGNED BY ALL APPLICANTS)*

TO: THE CHIEF EXECUTIVE OFFICER, MEDICAL COUNCIL

I HEREBY DECLARE AND NOTE THAT:-

(a)	the information contained in this form and all documentation* provided in support of my application is true and accurate to the best of my knowledge and belief and I have signed this form in my own handwriting;
(b)	I have read and noted carefully the Medical Council's Registration Rules 2011 and the current Guide to the Application Procedure and Registration Rules;
(c)	I have read and understood the current edition of the Medical Council's *Guide to Professional Conduct and Ethics*;
(d)	I undertake to comply with paragraph 50.1 of the Medical Council's *Guide to Professional Conduct and Ethics* regarding professional indemnity cover (see overleaf);
(e)	I hereby acknowledge and accept that failure by me to enclose all documents required by the Medical Council will result in my application being declared invalid and the application fee being forfeited;
(f)	I possess the skills to communicate effectively with patients and colleagues in the Republic of Ireland. ***IMPORTANT*** *Under EU freedom of movement legislation, the Medical Council is not entitled to require evidence of English language proficiency from EU citizens. The Medical Council strongly urges that all applicants for whom English is not their first language should attempt the IELTS to ensure that they have sufficient language skills to practise medicine in Ireland. Applicants should note that they may be required by employers or agencies to meet certain English language requirements. The Medical Council's Guide to Professional Conduct and Ethics states: "if you do not have the professional* ***or language skills****...you* ***must*** *refer the patient to a colleague who can meet those requirements." It may be considered professional misconduct if a medical practitioner is unable to communicate effectively with their patients and colleagues.* ***See overleaf for examples of evidence of communication skills***.
(g)	I am familiar with the legislation appertaining to the practice of medicine in the Republic of Ireland;
(h)	I am willing to attend the Medical Council's offices to be interviewed in relation to this application, if required;
(i)	I have not been suspended, erased or prohibited from practising medicine, or from being registered as a medical practitioner in any country and, to the best of my knowledge, there is no inquiry or disciplinary proceedings in being or contemplated against me in any country, **unless** otherwise indicated in **Q.8** of Section 8 of this application form;
(j)	I know of no reason why the Medical Council should not grant me registration in the Register of Medical Practitioners in accordance with the provisions of the Medical Practitioners Act 2007, as amended by the Health (Miscellaneous Provisions) Act 2007;
(k)	I acknowledge that the granting of registration is at the discretion of the Medical Council under the provisions of the Medical Practitioners Act 2007 and the Registration Rules 2011;
(l)	I hereby consent and give authority to the Medical Council to make any enquiry/ies with any body or person in pursuance of my application for registration;
(m)	I understand that canvassing of Council Members, training bodies, referees or any other party in relation to my application is prohibited. I acknowledge that canvassing will not assist my application and could be deemed inappropriate. I accept that reports of canvassing will be notified to the Medical Council.
(n)	I have read and understood the statutory provisions under section 41 subsections (1), (2), (3), (4) and (5) and section 55(1) and (3) of the Medical Practitioners Act 2007 overleaf.

***Under current Medical Council policy, if an applicant provides any documentation in support of an application for registration which is later found to be a forgery, the applicant will be refused registration. See Registration Rule A.3.(iv).**

SIGNATURE OF APPLICANT: _____ DATE: _____

PLEASE NOTE:
IN THE UNLIKELY EVENT THAT MORE THAN THREE MONTHS HAVE ELAPSED BY THE TIME A DECISION IS MADE REGARDING YOUR APPLICATION, YOU MAY BE REQUIRED TO SIGN THIS DECLARATION AGAIN.

Evidence of effective communication skills which are sufficient for the practice of medicine could include any of the following: (please tick box(es) applicable to you)

- ☐ The applicant obtained their basic medical degree and completed their internship training through English in a country where English is the primary language, e.g. Ireland, UK, Canada, Australia; or
- ☐ The applicant has been awarded a Higher Qualification listed in Appendix A of the Registration Rules which was obtained through English; or
- ☐ The applicant has a current Academic IELTS Certificate with an overall band score of 7.0 and a minimum score of 6.5 in each module, or
- ☐ The applicant has passed another equivalent English language test.
- ☐ If you have other evidence, please specify:

EXTRACTS FROM THE MEDICAL PRACTITIONERS ACT 2007:

Section 41

(1) A person is guilty of an offence if the person-
  (a) contravenes section 37(a) or (b) or 40(2),
  (b) falsely represents to be a registered medical practitioner,
  or
  (c) being a registered medical practitioner, falsely represents to be registered in a division of the register other than the division in which the person is registered.

(2) A person is guilty of an offence if the person causes or permits another person to make representations about the first-mentioned person that, if made by the first-mentioned person, would be an offence under subsection (1).

(3) A person is guilty of an offence if the person, with intent to deceive, makes with regard to another person any representation that –
  (a) the first-mentioned person knows to be false, and
  (b) if made by the other person would be an offence by the other person under subsection (1).

(4) A person is guilty of an offence if the person makes or causes to be made any false declaration or misrepresentation for the purpose of obtaining registration.

(5) A person guilty of an offence under this section is liable –
  (a) on summary conviction, to a fine not exceeding €5,000 or imprisonment for a term not exceeding 6 months or both,
  (b) on conviction on indictment-
    (i) in the case of a first offence, to a fine not exceeding €130,000 or to imprisonment for a term not exceeding 5 years or both,
    (ii) in the case of any subsequent offence, to a fine not exceeding €320,000 or to imprisonment for a term not exceeding 10 years or both.

Section 55

(1) For the purpose of keeping the register correct, the Council shall from time to time as occasion requires correct all clerical errors in the register, remove therefrom all entries therein procured by fraud or misrepresentation, enter in the register every change which comes to the Council's knowledge in the addresses of the registered medical practitioners, and remove the registration of all registered medical practitioners whose death has been notified to, or comes to the knowledge of, the Council.

…

(3) The Council shall take such steps as it considers necessary from time to time to ensure that the particulars entered in the register are accurate.

EXTRACT FROM THE MEDICAL COUNCIL'S *GUIDE TO PROFESSIONAL CONDUCT AND ETHICS FOR REGISTERED MEDICAL PRACTITIONERS:*

50 Professional Indemnity

50.1 You must ensure that you have adequate professional indemnity cover for all healthcare services you provide.

PLEASE ANSWER ALL QUESTIONS.
IF A QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "NOT APPLICABLE" IN THE SPACE PROVIDED.

9. CHECKLIST 1 – TO BE COMPLETED BY ALL APPLICANTS

PLEASE TICK THE APPROPRIATE BOXES TO INDICATE WHICH DOCUMENTS ARE ENCLOSED

The required documentation specified below **must** be provided with your application. **We cannot process incomplete applications**. The Medical Council reserves the right to return incomplete applications and/or declare them invalid.

- **All copy documents must be notarised by a Notary Public or attested by a Justice of the Peace/Commissioner for Oaths/Member of An Garda Siochána (documents signed by a Police Officer from another country are not acceptable).**

- **They should confirm that the copy is a true copy of the original document, give their full name and sign, date and officially stamp each copy document.**

- **All documents which are not in the English language must be attached to an English language translation issued and officially stamped by an official translator.**

- **The name and address of the translator used must be included, to allow for verification. Failure to do so could result in a delay in processing your application.**

☐	(a)	Completed Application Form. [All questions must be answered and the Declaration must be signed.]
☐	(b)	Notarised/attested copy of my current passport. [Where claiming refugee status, applicants must provide a notarised/attested copy of their GNIB Card and travel document.]

CERTIFICATES OF GOOD STANDING:

☐	(c)	An original Certificate of Current Professional Status/Good Standing, dated within the last **3 months**, **is being sent directly** to the Medical Council from all overseas registration authorities with whom I am or have been registered within the past **five years**. [NOTE: If the name on your degree differs to the name on your Certificate, we also require the authority to confirm that you are one and the same person.]

OR

☐	**Where an applicant has not held registration with any competent authority in the past five years** - a Statement that I have not practised medicine during the past **five years**, explaining how I have been occupied during this time. [NOTE: If you have been studying or undertaking examinations during this time, evidence of same is required (not necessary if applying for internship registration).]

FEES:

☐	(d)	Current **non-refundable** application fee (up-to-date fees available on our website). [NOTE: The registration year runs from 1st July to 30th June. If deemed eligible, you will be required to pay the appropriate registration fee prior to being registered. If a doctor is registered during the registration year, they are required to pay a retention fee on or before the following 1st July.] Please specify amount being paid: €_____ and payment method: _____

I enclose the above documentation and fees in support of my application for registration, pursuant to the provisions of the Medical Practitioners Act 2007 as amended.

SIGNATURE OF APPLICANT: _____ DATE: _____

10. PAYMENT OF FEES

Please note that the application fee is **non-refundable.** Please consult our website for the most up-to-date information regarding application fees at:
https://www.medicalcouncil.ie/registration/fees.asp.

Method of Payments:
Payments may be made to the Medical Council by Bank Draft or Credit / Laser Card.

1. By Bank Draft
Bank drafts are acceptable provided:
(a) they are in Euro and are **payable at an Irish Bank in Ireland**. (If they are in Euro but payable at a foreign bank these will be returned as they will incur bank charges which may differ from day to day.) OR
(b) they are acceptable in Sterling payable at a British Bank in the U.K. OR
(c) they are acceptable in U.S. dollars payable at an American Bank in the U.S.

2. Credit / Laser Cards
Payments may be made by Visa or Mastercard or by Lasercard by completing the form below.
An additional fee of 2.02% will apply to all VISA and MASTERCARD payments and a fee of €0.25 for all LASERCARD transactions. If you require any assistance regarding the above, please contact the Council's Finance section at +353-1-4983100.

PLEASE COMPLETE THIS FORM IF PAYING BY CREDIT / LASER CARD
(THIS PAGE WILL BE DETACHED AND SENT TO OUR FINANCE SECTION WHEN YOUR COMPLETE APPLICATION IS RECEIVED.)

Doctor's Name: _____

Registration Number (if known): _____

CREDIT CARD NUMBER																Exp Date	M	M	Y	Y

CVV NO. (last 3 digits on back)			

☐ VISA ☐ MASTERCARD

LASERCARD NUMBER																		Exp Date	M	M	Y	Y

Name of card holder: _____

Address of card holder: _____

_____

Signature: _____ Date: _____

AMOUNT TO BE DEBITED:
(An additional fee of 2.02% will apply to all VISA/MASTERCARD payments and €0.25 for all LASER transactions).
REASON FOR PAYMENT: DOCUMENT EXAMINATION FEE (LEVEL 1 ASSESSMENT)

€

Office Use Only:

PLEASE COMPLETE THIS FORM IF YOU WISH TO AUTHORISE THE MEDICAL COUNCIL TO TAKE A FURTHER PAYMENT BY CREDIT / LASER CARD FOR REGISTRATION (IF GRANTED)

(THIS PAGE WILL BE DETACHED AND SENT TO OUR FINANCE SECTION WHEN YOUR COMPLETE APPLICATION IS RECEIVED.)

PLEASE ANSWER ALL QUESTIONS.
IF A QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "NOT APPLICABLE" IN THE SPACE PROVIDED.

Doctor's Name: _____

Registration Number (if known): _____

Credit Card: Visa ☐ Mastercard ☐

CREDIT CARD NUMBER																	Exp Date	M	M	Y	Y

CVV NO. (last 3 digits on back)			

LASERCARD NUMBER																		Exp Date	M	M	Y	Y

Name of card holder: _____

Address of card holder: _____

_____

Signature: _____ Date: _____

AMOUNT TO BE DEBITED:
(An additional fee of 2.02% will apply to all VISA/MASTERCARD payments and €0.25 for all LASER transactions).
REASON FOR PAYMENT: REGISTRATION FEE

€

Office Use Only:

IMPORTANT:
Please note that the application fee is **non-refundable** and a registration fee is payable (if granted) for the remainder of the current registration year. The registration year runs from 1st July to 30th June the following year. It is the policy of the Council to grant registration on the date the application is complete, unless otherwise requested by the applicant before being registered.