**FORM IR1** **OFFICE USE ONLY:** REGISTRATION REFERENCE NUMBER: | | | | | | |

☐ Grad IRL ☐ Grad EU

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 FOR INTERNSHIP REGISTRATION**
**IN THE TRAINEE SPECIALIST DIVISION OF THE REGISTER OF MEDICAL PRACTITIONERS**
**UNDER THE PROVISIONS OF THE MEDICAL PRACTITIONERS ACT 2007**

**ALL 9 PARTS OF THIS APPLICATION FORM MUST BE COMPLETED INCLUDING THE CHECKLIST(S)**
*NOTE: IF YOU HAVE COMPLETED YOUR INTERNSHIP TRAINING, THIS IS THE WRONG FORM. YOU SHOULD COMPLETE THE GENERIC APPLICATION FORM FOR REGISTRATION.*

THE MEDICAL COUNCIL RESERVES THE RIGHT TO RETURN INCOMPLETE APPLICATIONS AND/OR DECLARE THEM INVALID.
YOU **MUST** NOTE THE RELEVANT INSTRUCTIONS UNDER WHICH YOUR APPLICATION WILL BE CONSIDERED.

## 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). Application Fee: **€310** |
| | **CATEGORY 2:** EU/EEA or Swiss citizen qualified in an EU/EEA member state or in Switzerland. Application Fee: **€310** |
| | **CATEGORY 3:** Non-EU citizen who qualified in an EU/EEA member state or in Switzerland. Application Fee: **€310** |

***IMPORTANT:*** *IF YOU MEET NONE OF THE ABOVE CRITERIA YOU ARE NOT ELIGIBLE FOR INTERNSHIP REGISTRATION. PLEASE CONTACT THE MEDICAL COUNCIL DIRECTLY BEFORE COMPLETING THIS FORM.*

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

***NOTE: IF GRANTED INTERNSHIP REGISTRATION, YOU WILL BE REGISTERED FOR ONE YEAR [NORMALLY FROM 1ST JULY TO 30TH JUNE OR 1ST JANUARY TO 31ST DECEMBER.] IF YOU REQUIRE AN EXTENSION OF YOUR INTERNSHIP REGISTRATION FOR A FURTHER PERIOD OF SIX MONTHS / ONE YEAR, A RETENTION FEE IS PAYABLE ON EXPIRY OF YOUR REGISTRATION.***
***+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. PERSONAL DETAILS

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

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

**+°SURNAME (AS IT WILL APPEAR 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 6.3 OF THE CURRENT ETHICAL GUIDE.*

**+°FORENAMES (AS THEY WILL APPEAR 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.*

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

**+°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.*

°**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.* |

**COUNTRY IN WHICH YOU WERE BORN:**

°**COUNTRY/IES OF WHICH YOU ARE A CITIZEN:**

1

2

3

**PLEASE TICK THE APPROPRIATE BOX ABOVE TO INDICATE THE COUNTRY THAT ISSUED THE PASSPORT**

**PASSPORT NUMBER:** **EXPIRY DATE:** D D M M Y Y Y Y

## 3. PROFESSIONAL QUALIFICATIONS

**+° PRIMARY MEDICAL QUALIFICATION(S) (ABBREVIATIONS):**

*NOTE: THE QUALIFICATION TO BE ENTERED IS THE MEDICAL QUALIFICATION ON WHICH YOUR APPLICATION IS BASED*

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***EXAMPLE:*** | M | B | | B | C | h | | N | U | I | | | | |

**+° DATE OF CONFERRAL:**

D D M M Y Y Y Y

**DATE YOUR UNDERGRADUATE MEDICAL COURSE...**

**COMMENCED:** M M Y Y Y Y **°ENDED:** M M Y Y Y Y

**LANGUAGE OF INSTRUCTION DURING YOUR UNDERGRADUATE COURSE:**

**° COUNTRY IN WHICH YOU QUALIFIED:**

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

°**NAME AND ADDRESS OF MEDICAL SCHOOL:** (PLEASE INCLUDE INTERNATIONAL CODES)

Name of Medical School:

Address:

**CONTACT DETAILS OF MEDICAL SCHOOL:** (PLEASE INCLUDE INTERNATIONAL CODES)

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Email address: | | | | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | | | | | | | | | | |
| Fax: | | | | | | | | | | | | | | | | | | | |
| Name of University (if different from Medical School): | | | | | | | | | | | | | | | | | | | |

**DO YOU INTEND PRACTISING IN INDIVIDUALLY NUMBERED, IDENTIFIABLE INTERN TRAINING POSTS?**

☐ Yes ☐ No (Please tick appropriate box)

*NOTE: SEE PARAGRAPH 5.2 OF THE GUIDE. IF IT IS NOT YOUR INTENTION TO PRACTISE IN INDIVIDUALLY NUMBERED, IDENTIFIABLE INTERN TRAINING POSTS, YOU MAY NOT BE ELIGIBLE FOR INTERNSHIP REGISTRATION IN IRELAND.*

**COUNTRY WHERE YOU WILL CARRY OUT YOUR INTERNSHIP:**

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | |

**NAME OF HOSPITAL(S) WHERE YOU WILL CARRY OUT YOUR INTERNSHIP TRAINING IN IRELAND: (IF KNOWN)**

**NOTE:** *IF YOU DO NOT INTEND PRACTISING IN INTERNSHIP TRAINING POSTS IN IRELAND, YOU DO NOT MEET THE REQUIREMENTS FOR INTERNSHIP REGISTRATION IN IRELAND. GRADUATES OF IRISH MEDICAL SCHOOLS SHOULD ENSURE WITH THE DEAN/HEAD OF THEIR MEDICAL SCHOOL THAT ANY INTERNSHIP TRAINING TO BE UNDERTAKEN OUTSIDE THE STATE IS PRE-APPROVED.*

**DATE YOU EXPECT TO COMMENCE YOUR INTERNSHIP:** (DD/MM/YYYY)

| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## 4. REGISTRATION DETAILS

**HAVE YOU APPLIED TO THIS MEDICAL COUNCIL BEFORE FOR ANY TYPE OF REGISTRATION?**

☐ Yes ☐ No (Please tick appropriate box)

**IF YES, PLEASE STATE TYPE OF REGISTRATION:** (Please tick appropriate box/es)

☐ Full ☐ Internship ☐ Temporary (only if applied prior to 16/03/09)

☐ Internship ☐ Trainee Specialist ☐ Specialist ☐ General ☐ Visiting EEA

**+°REGISTRATION / REFERENCE NUMBER QUOTED TO YOU IN PREVIOUS CORRESPONDENCE (IF ANY):**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

**HAVE YOU HAVE EVER BEEN REGISTERED FOR THE PURPOSE OF ENGAGING IN THE PRACTICE OF MEDICINE AS A REGISTERED MEDICAL PRACTITIONER?** (please tick appropriate box below and provide details overleaf, if applicable)

☐ I have never been registered with another authority

☐ I am / have been registered with another authority, the details of which are provided overleaf.

☐ I am/have been registered with another health-related authority, the details of which are provided overleaf (e.g. pharmaceutical societies, physiotherapists, etc).

*PLEASE ANSWER <u>ALL</u> QUESTIONS.*
*IF A QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE "N/A" IN THE SPACE PROVIDED.*

**NAME AND ADDRESS OF REGISTRATION OR OTHER HEALTH-RELATED AUTHORITY** (IF APPLICABLE)**:**
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 PROVIDE DETAILS ON A SEPARATE PAGE AND ATTACH.*

## 5. <u>IMPORTANT QUESTIONS</u>

***NOTE: IT IS IMPERATIVE THAT YOU ANSWER <u>EACH</u> OF THE FOLLOWING 7 QUESTIONS.***

**Q.1: HAVE YOU EVER BEEN CONVICTED IN A COURT OF LAW (<u>INCLUDING</u> A DRUNKEN DRIVING CHARGE)?**

☐ Yes ☐ No (Please tick appropriate box)

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

**Q.2: 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.]
☐ Yes ☐ No (Please tick appropriate box)

IF YES, PLEASE PROVIDE FULL PARTICULARS, INCLUDING NAME, ADDRESS AND CONTACT DETAILS OF YOUR TREATING DOCTOR(S) IN THE SPACE PROVIDED ON PAGE 5 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

**Q.3: HAVE YOU EVER BEEN TREATED FOR:** (Please tick appropriate box/es. Tick "yes" for both, if applicable.)
**ALCOHOL DEPENDENCE?** ☐ Yes ☐ No **AND/OR** **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 5 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

**Q.4: 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 (Please tick appropriate box)

IF YES, PLEASE PROVIDE FULL PARTICULARS, INCLUDING THE NAME OF THE BODY WHICH CONDUCTED THE ASSESSMENT, IN THE SPACE PROVIDED ON PAGE 5 AND PROVIDE A STATEMENT ON A SEPARATE PAGE AND ATTACH.

**Q.5: HAS ANY REGISTRATION AUTHORITY EVER REFUSED TO GRANT YOU REGISTRATION TO ENGAGE IN THE PRACTICE OF MEDICINE AS A REGISTERED MEDICAL PRACTITIONER?**
☐ Yes ☐ No (Please tick appropriate box)

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

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

**IMPORTANT:** IF YOU ANSWERED '**YES**' TO QUESTIONS **2, 3 OR 4** ON THE PREVIOUS PAGE, YOU MUST PROVIDE **FULL PARTICULARS** BELOW, INCLUDING NAME, ADDRESS AND CONTACT DETAILS OF YOUR TREATING DOCTOR(S) (FOR QUESTIONS 3/4) 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:**

_____

_____

_____

**Q.6: 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 OR WERE REGISTERED? [*INCLUDE ANY ERASURE DUE TO NON-PAYMENT OF FEES.*]**

☐ Yes ☐ No (Please tick appropriate box)

**NOTE: IF YOU ANSWERED "YES" TO Q.6, YOU ARE REQUIRED TO PROVIDE FULL PARTICULARS.**

## 6. PROFESSIONAL EXPERIENCE (TO BE COMPLETED BY ALL APPLICANTS)

PLEASE INDICATE BELOW, IN DATE ORDER, WORKING FORWARD FROM THE DATE YOU GRADUATED TO DATE, HOW AND WHERE YOU HAVE BEEN OCCUPIED SINCE OBTAINING YOUR BASIC (PRIMARY) MEDICAL DEGREE. 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. **NOTE: WRITE "NOT APPLICABLE" IF APPLYING FOR REGISTRATION IMMEDIATELY AFTER GRADUATION.**

| **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 | | |
| FROM: D D M M Y Y | TO: D D M M Y Y | | |

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

## 7. 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 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;

(d) I possess the linguistic capacity to communicate with patients in the Republic of Ireland;

(e) I possess knowledge of the legislation appertaining to the practice of medicine in the Republic of Ireland;

(f) I am willing to attend the Medical Council's offices to be interviewed in relation to this application, if required;

(g) 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 Section 5, **Q.7** of this application form;

(h) 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;

(i) 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;

(j) 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;

(k) 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.

(l) I have read and understood the following statutory provisions under section 41 subsections (1), (2), (3), (4) and (5) and section 55(1) and (3) of 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.

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

**8. CHECKLIST – TO BE COMPLETED BY ALL APPLICANTS**

- 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. You must note the relevant requirements for each category/division set out below (please see page 1 for eligibility categories).
- **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.**

**PLEASE TICK THE APPROPRIATE BOXES TO INDICATE WHICH DOCUMENTS ARE ENCLOSED**

| | | |
|---|---|---|
| ☐ | (a) | Completed Application Form. [All questions must be answered and the Declaration must be signed.] |
| ☐ | (b) | Notarised/attested copy of my current passport. |
| ☐ | (c) | Notarised/attested copy of my basic (primary) medical qualification which I received on the day I was conferred, clearly displaying the full date of conferral. See paragraph 9.6 of the Guide. [**Not required if applying under Category 1 - please see page 1 for Categories.**] |

**CERTIFICATES OF GOOD STANDING:**

| | | |
|---|---|---|
| ☐ | (d) | 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 since graduation. [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**

| | |
|---|---|
| ☐ | I have not practised medicine since graduation. |

**FEES:**

| | | |
|---|---|---|
| ☐ | (e) | Current **non-refundable** application fee (up-to-date fees available on our website). [See form on page 9.] [NOTE: Interns are registered initially for one calendar year and must pay a retention fee on expiry of their registration, which normally occurs either on 1st July or 1st January.]<br>Please specify payment method: _____ |

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

SIGNATURE OF APPLICANT: _____ DATE: _____

## 9. 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:** APPLICATION FOR INTERNSHIP REGISTRATION

**€310**

Office Use Only: