APPLICATION FORM FOR THE MEMBERSHIP EXAMINATION
(Examinations in 2019)

All information given will be treated in strict confidence

Please read the REVISED Examination Regulations for 2019 before completing this form

Is this the first time to apply for the examination? (Please tick one box below)

☐ Yes
☐ No  Date of last examination: ............

Have you been given a permanent candidate number? (Please tick one box below)

☐ Yes Enter your permanent candidate number: ............
☐ No

PERSONAL AND CONTACT INFORMATION

1 Family name: ....................................................................................................................................

2 First and middle names: ..................................................................................................................

3 Address for examination correspondence:
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4 Nationality: ..................................................................................................................................

5 Work Place: ......................................................................................................................................

6 Telephone numbers / email:
   Home: ........................................................................................................................................
   Work: ...........................................................................................................................................
   Fax: .............................................................................................................................................
   E-mail: ..........................................................................................................................................
EDUCATION AND TRAINING

7. Medical school: ...........................................................................................................................

8. Degree: .................................................................

9. Date of graduation: ................................................. (Day / month / year)

10. Registration (or staff) number, If applicable: .................................................................

11. Date of registration: .................................................... (Day / month / year)

If you have undertaken or are undertaking vocational (residency) training for general practice (or family medicine) please answer questions 12 and 13.

12. Actual or expected date of completion of training: ........................................ (Day / month / year)

13. Where trained/training: .................................................................

ELIGIBILITY (for new applicants)

14. Present status: please tick box (a) OR (b) below

☐ (a) I have been eligible to practice as an independent (unsupervised) GP/Family Physician for at least 3 years and I am currently practicing as an active primary care (family) practitioner

☐ (b) I am undertaking vocational training for general practice and understand that I must provide evidence of having successfully completed 3 years of my training before I may take up Membership of the College

MODULES TO BE TAKEN DURING 2019

I wish to be entered for the modular MRCGP examination in the following session:

☐ Spring 2019 session

☐ Autumn 2019 session

In the session ticked above, I apply to take the following modules (please tick the appropriate boxes below, and answer the supplementary questions):

☐ * Written Paper

☐ * Multiple Choice Paper

☐ * CCSA *preferred session (please tick one): morning ☐ afternoon ☐
CANDIDATE'S STATEMENT

I hereby apply to sit the Membership examination. **I have read and agree to the conditions set out in the REVISED Examination Regulations for 2019.**

If accepted for Membership I undertake to continue approved postgraduate study while I remain in active general practice, and to uphold and promote the aims of the College to the best of my ability. I understand that on being accepted for Membership a first year’s subscription will be payable to the College, and thereafter an annual subscription fee.

I wish to sit at least one module at the coming session and have entered the details above.

* I understand that the capacity of each module is limited and agree that my application and fees paid can be carried forward to the next available session if capacity has been reached in any of the modules I am applying for.

* I understand that the capacity of each CCSA session is limited and I agree to my allocation to the other session if my preferred session reaches capacity.

I attach (please tick):

- a photocopy of my current certificate of Registration (if applicable)
- a photocopy of my passport
- a photocopy of my qualification(s)
- 2 photographs of myself endorsed by a senior member of my department
- a copy of documentation as evidence of my eligibility as noted in answer to question 12 (certificate of **Current Employment as an independent GP/Family Physician with completion of 3 years in practice**), or (certificate of successful completion of 3 years of vocational training for general practice/family practice)
- a completed and valid certificate of competence in cardio-pulmonary resuscitation

This must be sent to the Examination Board no later than the date on which examination results will be issued in respect of the final module of the examination you will be taking i.e. the module or modules which, if passed, will qualify you to have passed the examination overall

- **The examination fee for each module in 2019 is:** **AED 4,000 AED**

Before proceeding for the payment. Kindly confirm first for the availability of the module

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New email: RDM1uanguc@dra.gov.ae  
Web site: [https://www.dha.gov.ae/en/PrimaryHealthCareCentres/HealthCenters/Pages/MRCGP.aspx](https://www.dha.gov.ae/en/PrimaryHealthCareCentres/HealthCenters/Pages/MRCGP.aspx)
6 Disability.

Do you have a disability? ☐ Yes ☐ No (please tick)

(Under the Disability Discrimination Act a disability is defined as physical, sensory or mental impairment which has, or had, a substantial and long-term adverse effect on a person’s ability to carry out normal day-to-day activities)

If yes, please indicate which of the following categories describes your disability:

- Wheelchair user ☐
- Person with physical disabilities ☐
- Visually impaired person ☐
- Hearing impaired person ☐
- Person with dyslexia ☐
- Person with speech impairment ☐
- Other disability ☐

Please provide details below, together with an indication of any particular requirements you may have in relation to the examination

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Signed: .......................................................... Date: .........................

APPLICATIONS SHOULD BE HAND LED OR SENT BY COURIER (e.g. DHL, ARAMEX, etc.) TO:

Office of General Coordinator
MRCGP International Exam Board
1st floor, Society of Engineers Building,
Al Wuheida Road, street 46, Al Mamzar, Deira
Dubai, United Arab Emirates
Timings: Sunday to Thursday from 8am till 2pm

Ms. Rhodora Cecilia Diaz Manlucu
Tel: + 971 4 502 – 4469 or 4470