Form MCI-07 (A)

BOARD OF GOVERNORS
IN SUPERSESSION OF MEDICAL COUNCIL OF INDIA
Pocket - 14, Sector - 8, Phase-I, Dwarka, New Delhi - 110 077
Phone : 011-25367033,25367035, 25367036,
Email : mci@bol.net.in, Website : http://www.mciindia.org

APPLICATION FORM FOR GRANT OF TEMPORARY PERMISSION U/S 14(1) OF THE INDIAN MEDICAL COUNCIL ACT, 1956 TO FOREIGN NATIONAL HOLDING NON-SCHEDULE MEDICAL QUALIFICATION FOR THE PURPOSES OF TEACHING/TRAINING/RESEARCH/CHARITABLE WORK ETC. IN INDIA FOR A LIMITED PERIOD.

(Please read the instructions carefully given in Appendix-I before filling the form.)

Application for Temporary Permission:

1.	NAME OF THE APPLICANT (IN BLOCK LETTERS)	
2.	FATHER'S NAME (IN BLOCK LETTERS)	
3.	PRESENT CORRESPONDENCE ADDRESS	
4.	PHONE, FAX NO. & E-MAIL ADDRESS	
5.	NATIONALITY	
6.	DATE OF BIRTH	

7. DETAILS OF ACADEMIC QUALIFICATION(S):

Sl. No.	Qualification (Primary and Specialist)	Name of University/ Board/Medical College with Country name	Year of Degree/ Diploma obtained

8.	WHETHER THE PRIMARY MEDICAL QUALIFICATION POSSESSED IS EQUIVALENT TO MBBS (MODERN SCIENTIFIC MEDICINE) OR IT IS IN OTHER FIELD OF MEDICINE.	
9.	DURATION OF PRIMARY MEDICAL AND SPECIALIST COURSE	PRIMARY _____YEARS SPECIALIST _____ YEARS

10. DETAILS OF REGISTRATION/LICENCE:

Name of the Registration/ License granting authority	Registration/ License Number	Date of issue of registration/License	Last date of validity of Registration/ License

11.	RIGHT TO PRACTICE (AREA OF PRACTICE) ON REGISTRATION OF ABOVE MENTIONED QUALIFICATION	
12.	DURATION/DATE OF INTERNSHIP, IF COMPLETED.	
13.	NAME OF THE HOSPITAL/ INSTITUTE IN INDIA WITH COMPLETE ADDRESS FOR THE PURPOSES OF TEACHING/ TRAINING/RESEARCH/ CHARITABLE WORK ETC. (SPECIFY THE PURPOSE)	
14.	PROPOSED DATE OF VISIT FOR TEACHING/TRAINING/ RESEARCH/ CHARITABLE WORK ETC.	
15.	NAME OF THE PERSON IN THE HOSPITAL/INSTITUTE IN INDIA WHO WILL BE RESPONSIBLE FOR THE LEGAL ISSUES REGARDING THE PATIENT CARE PROVIDED BY THE DOCTOR CONCERNED.	

16. DETAILS OF PASSPORT:

NAME OF ISSUING AUTHORITY	PASSPORT NUMBER	DATE OF ISSUE	DATE OF EXPIRY

17.	DETAILS OF FEES: AMOUNT IN INR ONLY:	DETAILS OF DEMAND DRAFT (a) NAME & ADDRESS OF ISSUING BANK .... (b) DEMAND DRAFT NO. ..... (c) Date: .....

SIGNATURE AND STAMP OF THE HEAD OF THE INSTITUTE/HOSPITAL IN INDIA

SIGNATURE OF THE APPLICANT

DATE: _____

PLACE: _____

APPENDIX-I

INSTRUCTIONS

1. THE APPLICATION FORM SHOULD BE PROPERLY AND NEATLY FILLED IN BY THE APPLICANT AND SHOULD BE SUBMITTED ALONG WITH THE FOLLOWING DOCUMENTS IN 2 (TWO) SETS: -

   a) COPY OF CURRENT REGISTRATION CERTIFICATE IN YOUR OWN COUNTRY DULY ATTESTED. IN CASE, THE DOCUMENTS ARE IN LANGUAGE OTHER ENGLISH THEN TRUE COPY OF THE DOCUMENT(S) ALONGWITH AUTHENTICATED COPY OF THE SAME IN ENGLISH VERSION, BE ATTACHED WITH THE APPLICATION.

   b) A CERTIFICATE FROM THE HEAD OF THE INSTITUTION/HOSPITAL UNDER WHICH THE CANDIDATE IS EMPLOYED / TO BE EMPLOYED TO THE EFFECT THAT SERVICES RENDERED BY THE FOREIGNER ARE FOR THE PURPOSE OF TEACHING, RESEARCH OR PRACTICE MEDICINE IN INDIA AND NOT FOR PERSONAL GAIN.

   c) COPY OF PASSPORT DULY SELF ATTESTED.

   d) COPIES OF ALL DEGREE/DIPLOMA DULY SELF VERIFIED. IN CASE, THE DOCUMENTS ARE IN LANGUAGE OTHER ENGLISH THEN TRUE COPY OF THE DOCUMENT(S) ALONGWITH AUTHENTICATED COPY OF THE SAME IN ENGLISH VERSION, BE ATTACHED WITH THE APPLICATION.

   e) SPONSORSHIP/APPOINTMENT/ACCEPTANCE LETTER FROM THE INSTITUTE/HOSPITAL CONCERNED IN INDIA (AS PER APPENDIX-II).

   f) NON REFUNDABLE APPLICATION FEE OF RS. 5000/- (RUPEES FIVE THOUSAND ONLY) + 18% GST BY A BANK DRAFT IN FAVOUR OF "THE SECRETARY, MEDICAL COUNCIL OF INDIA", PAYABLE AT NEW DELHI. ON REVERSE OF THE DRAFT, FOLLOWING DETAILS TO BE FILLED BY THE APPLICANT AND DULY SIGNED: -

      (i) Name

      (ii) Father's Name

      (iii) Purpose for which the draft submitted

      (iv) Telephone No with Code/Mobile No.

2 APPLICATION FOR TEMPORARY PERMISSION FOR FOREIGN NATIONALS FOR TRAINING/PRACTICE IN INDIA MUST BE RECEIVED THROUGH THE HOSPITAL/INSTITUTE IN INDIA ALONGWITH ALL DOCUMENTS AS MENTIONED ABOVE. NO DIRECT APPLICATION FROM THE FOREIGN NATIONALS WILL BE ENTERTAIED.

APPLICATION MUST BE RECEIVED IN THE COUNCIL OFFICE AT LEAST 2 MONTHS IN ADVANCE FROM THE SCHEDULED DATE OF TEACHING/ TRAINING/RESEARCH/CHARITABLE WORK ETC. IN A HOSPITAL/INSTITUTE IN INDIA.

3. INCOMPLETE APPLICATION WILL NOT BE ENTERTAINED.
4. APPLICANT IS ADVISED TO RETAIN COPY OF HIS/HER APPLICATION AND DRAFT FOR FUTURE REFERENCE.

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CHECK LIST for submission of documents

THE CANDIDATES ARE REQUESTED TO ENSURE THAT THE DOCUMENTS BE ENCLOSED AS PER THE ORDER IN THE CHECKLIST. ALL PAPERS/DOCUMENTS SHOULD BE NUMBERED ACCORDING TO THE CHECKLIST. PLEASE ARRANGE THE APPLICATION IN THE FOLLOWING ORDER & TICK MARK THE RELEVANT BOXES:

1.	Bank Draft	Yes	No
2.	Application form (Two sets)	Yes	No
3.	Copies of degree or diploma or certificate (Two sets)	Yes	No
4.	Certificate of permanent Registration (Two sets)	Yes	No
5.	Sponsorship/Appointment/Acceptance letter from the Hospital/Institution concerned in India (Two sets)	Yes	No
6.	Copy of passport (Two sets)	Yes	No
7.	Admission letter from the college/hospital where the training is to be scheduled	Yes	No

Signature _____

Dated _____

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MEDICAL COUNCIL OF INDIA

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ACKNOWLEDGEMENT

(To be filled by the candidate)

Received Application from Ms/ Mr.....

D/o/S/o Sh..... along with Bank Draft/DD No..... dated..... for Rs.....Drawn on Bank..... for issuance of Temporary Registration/Permission.

OFFICIAL SEAL

Signature of Receiving Official
with date

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APPENDIX-II

FORMAT FOR SPONSORSHIP LETTER TO BE ISSUED BY THE HEAD OF THE HOSPITAL/INSTITUTION IN INDIA:

To,

The Medical Council of India,
Pocket-14,
Sector-8, Phase-1,
Dwarka,
New Delhi – 110 077.

Subject: Request for temporary permission u/s 14(1) of the IMC Act, 1956 in respect of Dr……

Sir,

It is to inform you that Dr…… has been invited by …… for the purposes of …… from …… to ……on the following terms & conditions:-

i) He/she will be paid a salary/remuneration/stipend Rs…… per month.

ii) He/she will work purely for charitable purpose and not for monetary/financial gain.

iii) He/she will be provided accommodation and/or local travel.

iv) He/she will abide provisions contained in the "Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002", while practicing medicine/performing any kind of surgery in India.

It is further to inform you that Dr…… designation…… name of the hospital/institute…… will be fully responsible for the legal issues regarding the patient care to be provided by Dr……

Yours faithfully,

(Signature and stamp containing Name, Designation & name of the Hospital/Institute)