



FORM -3
(See Rule 38, 39 (ii))
Manipur Medical Council

APPLICATION FORM FOR CONTINUATION OF NAME IN THE REGISTER

Receipt No

Date

(for office use)

To,

The Registrar
Manipur Medical Council
Imphal

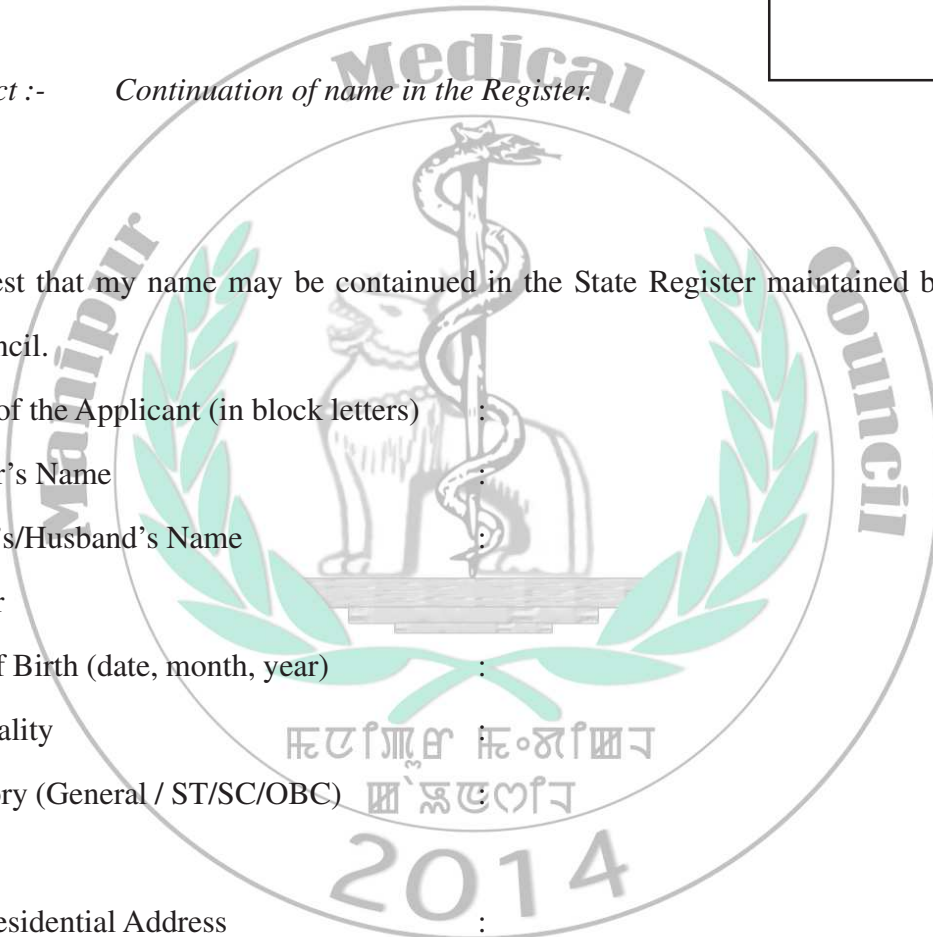
Affix passport
Size
photograph
attested

Subject :- Continuation of name in the Register.

Sir,

I request that my name may be contained in the State Register maintained by Manipur Medical Council.

1. Name of the Applicant (in block letters) :
2. Mother's Name :
3. Father's/Husband's Name :
4. Gender :
5. Date of Birth (date, month, year) :
6. Nationality :
7. Category (General / ST/SC/OBC) :
8.
 - a) Residential Address :
 - b) Permanent Address :
 - c) Professional Address :
9. Telephone No./ Mobile No./Fax No./
E-mail ID



10. Details of Qualifications :

Sl. No.	Description of Qualification	Name of the School/College/ Medical Institution	Name of the Board/ University/Licensing Body	Year of the completion Of Internship in case of MBBS in any other case year of passing examination

11. Manipur Medical Council :
Registration Certificate No. & Date

12. Present Occupation :

I submit herewith original certificates for verification and submit attested copies of the same certificates :-

- Two recent passport size photographs with name and signature at the backside.
- Manipur Medical Council Registration Certificate.
- MBBS Degree/ Post graduate Degree/ Diploma/ Post-Doctoral Degree Certificate.

I hereby submit a Bank Draft No. Dated
Prepared from (Bank) for Rs. 1500/- (Rupees one thousand five hundred)
as non-refundable fee in favour of 'The Manipur Medical Council' payable at Imphal.

(in case of late fee)

I hereby submit a Bank Draft No. Dated prepared
from (Bank) for Rs. being the late fee as non-refundable in
favour of 'The Manipur Medical Council' payable at Imphal.

DECLARATION

I solemnly affirm and declare that the particulars furnished above by me are true to the best of my knowledge and belief and I undertake to abide by the code of conduct & Ethics of Manipur Medical Council and Indian Medical Council and by the Rules of Manipur Medical Council.

Date :

Signature of the Applicant

(for office use only)

Received the above documents in original.

Signature of registered person.....

Name

Date



MMC Copy

Punjab & Sind Bank

Deulahland, Imphal

Date : _____

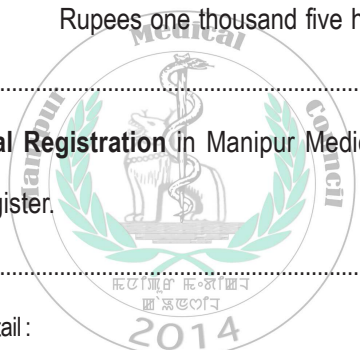
In favour of : **The Manipur Medical Council**

A/c # : **06751000017048**

Sum of : Rs. 1500/- (Case only)

in words : Rupees one thousand five hundred only

For **Renewal Registration** in Manipur Medical
Council Register.



Applicant's detail :

Name : _____

Date of Birth : _____

Mobile No. : _____

Email : _____

Signature of
depositor

Authorized Signatory
& Seal



Personal Copy

Punjab & Sind Bank

Deulahland, Imphal

Date : _____

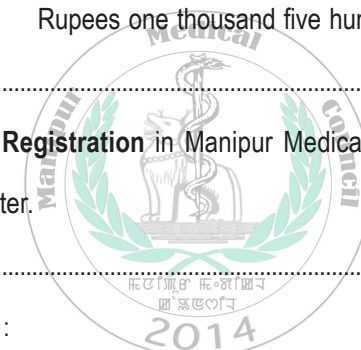
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Council Register.



Applicant's detail :

Name : _____

Date of Birth : _____

Mobile No. : _____

Email : _____

Signature of
depositor

Authorized Signatory
& Seal



Bank Copy

Punjab & Sind Bank

Deulahland, Imphal

Date : _____

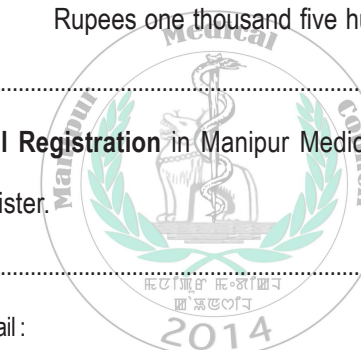
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Council Register.



Applicant's detail :

Name : _____

Date of Birth : _____

Mobile No. : _____

Email : _____

Signature of
depositor

Authorized Signatory
& Seal

The Bank copy will be retained by the Bank, MMC copy to be submitted to the Manipur Medical Council, and personal copy to be kept with the Applicant

Additional Format for synchronization of National Register and State Register (to be filled up by the applicant with effect from 15th April, 2021)

Sl. No.	Particulars	Information
1.	Name (as given in MBBS degree)	
2.	Recent photo (one copy to be affixed)	
3.	Father's Name	
4.	Present/Corresponding Address	
5.	Permanent address	
6.	Aadhaar Numer	
7.	Mobile Number	
8.	e-mail	
9.	Date of birth	
10.	Nationality	
11.	UG Degree	
i.	Name of Degree	
ii.	Name of Medical College/University	
iii.	Month & year of passing	
iv.	Registration number	
v.	Date of Registration	
vi.	Name(s) of register (National/State)	
vii.	Whether the registration is renewable or permanent	

Sl. No.	Particulars	Information
12.	(a) PG Degree (MD/MS)	
i.	Name of Degree	
ii.	Name of the Subject	
iii.	Name of Medical College/University	
iv.	Month & year of passing	
v.	Registration number	
vi.	Date of Registration	
vii.	Name(s) of register (National/State)	
viii.	Whether the registration is renewable or permanent	
12.	(b) PG (DNB from NBE)	
i.	Name of Degree	
ii.	Name of the Subject	
iii.	Name of Medical College/University	
iv.	Month & year of passing	
v.	Registration number	
vi.	Date of Registration	
vii.	Name(s) of register (National/State)	
viii.	Whether the registration is renewable or permanent	

Sl. No.	Particulars	Information
12.	(c) PG (Medical Diploma)	
i.	Name of Degree	
ii.	Name of the Subject	
iii.	Name of Medical College/University	
iv.	Month & year of passing	
v.	Registration number	
vi.	Date of Registration	
vii.	Name(s) of register (National/State)	
viii.	Whether the registration is renewable or permanent	
12.	(d) Super speciality (DM/MCH)	
i.	Name of Degree	
ii.	Name of the Subject	
iii.	Name of Medical College/University	
iv.	Month & year of passing	
v.	Registration number	
vi.	Date of Registration	
vii.	Name(s) of register (National/State)	
viii.	Whether the registration is renewable or permanent	
12.	(e) Super speciality (DNB)	
i.	Name of Degree	
ii.	Name of the Subject	
iii.	Name of Medical College/University	
iv.	Month & year of passing	
v.	Registration number	
vi.	Date of Registration	
vii.	Name(s) of register (National/State)	
viii.	Whether the registration is renewable or permanent	

Sl. No.	Particulars	Information
13.	Name of the Institute/Hospital/Clinic where engaged in teaching /research/practice of Medicine	Government/Private/Own Teaching/Non-teaching Research/Non research
14.	Complete Address/Contact details of the Institute/Hospital/Clinic mentioned in Item No.13 above	
15.	Name of person in Hospital/Institute mentioned above in Item No.13 above who is responsible for legal issues regarding patient care provided by the Doctor.	
16.	Registered Medical Practitioner (RMP) no. of the person mentioned in item no.15 above	

Date :

Signature of the Doctor

(Complete name of the Doctor)