



FORM
Manipur Medical Council
Application form for
Provisional Medical Registration

Receipt No

Date

(for office use)

To,

The Registrar

Manipur Medical Council

Imphal

Affix passport
Size
photograph
attested

Subject :- Provisional registration of name in the register.

Sir,

I hereby request that my name and other particulars mentioned below may be entered in the Provisional State Register of Manipur Medical Council as required.

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

10. Training being under taken :

a. Compulsory Rotating Internship :

Or,

b. Practical Training Course :

c. Date of joining the Training :

11. Qualifications :

a) General Degree

Sl. No.	Description of Qualification	Name of School/ College/Institution	Name of the Board/University	Year of Qualification

b) Medical Degree

Sl. No.	Description of Qualification	Name of the College/Institution	Name of the University	Year and month of Passing MBBS

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

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

Instructions :

- i) Birth Certificate, Matriculation Certificate, HSSL Certificate/SSC Exam Certificate with date of birth.
- ii) MBBS Degree and marksheets of all examinations.
- iii) Other evidence in support of my having obtained the qualification which I possess.
- iv) Three recent passport size photographs with name and signature at the backside.
- v) Download the Bank Deposit Slip Rs. 2000/- in favour of “ The Manipur Medical Council”, A/c.# 0652200100007106, Punjab and National Bank, RIMS, Imphal.

MMC Copy



Punjab National Bank

RIMS, Lamphel, Imphal

Date : _____

In favour of : **The Manipur Medical Council**
A/c # : **0652200100007106**
Sum of : **Rs. 2000/- (Case only)**
in words : **Rupees one thousand only**

For Allotment of Provisional Registration in
Manipur Medical Council.

Applicant's detail :

Name : _____
Date of Birth : _____
Mobile No. : _____
Email : _____

Signature of depositor _____
Authorized Signatory & Seal _____

Personal Copy



Punjab National Bank

RIMS, Lamphel, Imphal

Date : _____

In favour of : **The Manipur Medical Council**
A/c # : **0652200100007106**
Sum of : **Rs. 2000/- (Case only)**
in words : **Rupees one thousand only**

For Allotment of Provisional Registration in
Manipur Medical Council.

Applicant's detail :

Name : _____
Date of Birth : _____
Mobile No. : _____
Email : _____

Signature of depositor _____
Authorized Signatory & Seal _____

Bank Copy



Punjab National Bank

RIMS, Lamphel, Imphal

Date : _____

In favour of : **The Manipur Medical Council**
A/c # : **0652200100007106**
Sum of : **Rs. 2000/- (Case only)**
in words : **Rupees two thousand only**

For Allotment of Provisional Registration in
Manipur Medical Council.

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)