



PAKISTAN MEDICAL COMMISSION

G-10/4, MAUVE AREA ISLAMABAD.

Website: www.pmc.gov.pk

Email: licensing@pmc.gov.pk

APPLICATION FOR FULL LICENSE

(HOLDERS OF PAKISTAN PROVISIONAL LICENSE)

Attach Two Color
Photographs

FORM WILL BE FILLED IN CAPITAL LETTERS ONLY

PMC REGISTRATION NO:	
NAME:	
FATHER NAME:	
CNIC:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
PASSPORT NO: (IF FOREIGN NATIONAL)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
NATIONALITY:	
DATE OF BIRTH:	_____ [date] _____ [month] _____ [year]
GENDER	FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>
HOUSE JOB INSTITUTION:	
NLE REGISTRATION NO. (IF GRADUATED AFTER SEPT 2020)	
PROVINCE/DISTRICT:	
MAILING /POSTAL ADDRESS:	
PERMANENT ADDRESS:	
MOBILE:	
EMAIL:	

UNDERTAKING

I undertake to abide by the code of Medical Ethics prescribed by the PMC for registered Medical/Dental practitioners and will inform the PMC of any change of address or residence of practice within thirty days. If considered necessary, PMC may disclose any information when asked from any of my educational institution and I shall not hold PMC liable for such disclosure. I take full responsibility of authenticity of documents submitted along with this application and shall be liable for any misrepresentation. I am aware that more than one agency is involved in the verification, and considerable time may be consumed in the process.

Signature of Applicant: _____

Date: _____

✓ **CHECK LIST**

1. Copy of House Job Certificate issued by Institute duly signed by Head of Institution.

✓ **FEE**

Fee for Full License (02 Years only)

Rs. 4,000/-

- A Bank deposit slip of Rs _____ No. _____ Dated _____
Name of issuing Bank & Branch _____

All payments shall be made in favor of "Pakistan Medical Commission" through designated payment channels available on PMC website

FOR OFFICE USE ONLY

Received Rs. _____ Receipt No. _____ Date: _____

PMC REGISTRATION

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 NO:

Registration Date: _____ Valid Upto: _____

Scrutinized by :(1) _____(2) _____

Secretary / Authorized: _____