



PAKISTAN MEDICAL COMMISSION

G-10/4, MAUVE AREA ISLAMABAD.

Website: www.pmc.gov.pk
Email: licensing@pmc.gov.pk

Attach Two Color
Photographs

APPLICATION FOR TEMPORARY LICENSE

(FOR FOREIGN LICENSE HOLDER)

FORM WILL BE FILLED IN CAPITAL LETTERS ONLY

QUALIFICATION	MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/>
NAME:	
FATHERS NAME:	
PASSPORT NO:	<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"/>
NATIONALITY:	
DATE OF BIRTH:	_____ [date] _____ [month] _____ [year]
GENDER	FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>
MAILING /POSTAL ADDRESS (In Home Country):	
MOBILE:	
EMAIL:	
FOREIGN LICENSE NO:	
NAME OF LICENSING AUTHORITY:	
COUNTRY:	
POST GRADUATE QUALIFICATIONS RECOGNIZED IN LICENSED COUNTRY:	
ENTRY IN SPECIALIST REGISTER:	
PURPOSE FOR TEMPORARY LICENSE:	Training <input type="checkbox"/> Procedure <input type="checkbox"/>
NAME OF SPONSORING INSTITUTION:	
ADDRESS OF SPONSORING INSTITUTION:	
CONTACT PERSON AT INSTITUTION:	
CONTACT NUMBER:	
DATE ON WHICH LICENSE REQUIRED	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
PERIOD OF LICENSE	3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/>

- License will be sent by courier to Sponsoring Institution

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 Foreign License of Applicant (With English Translation)
2. Copy of Evidence of Applicant's Post Graduate Qualifications (With English Translation)
3. Copy of Sponsoring Institutions Letter

✓ Fee

Fee for 3 month Temporary License

Rs. 10,000/-

Fee for 6 month Temporary License

Rs.15,000/-

- 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

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REGISTRATION NO:

Registration Date: _____ Valid Upto: _____

Scrutinized by :(1) _____ (2) _____

Secretary / Authorized: _____