LEGAL NOTICE NO. 161

THE MEDICAL PRACTITIONERS AND DENTISTS ACT

(Cap. 253)

IN EXERCISE of the powers conferred by section 23 of the Medical Practitioners and Dentists Act, the Cabinet Secretary for Health, after consultation with the Board makes the following Rules:

THE MEDICAL PRACTITIONERS AND DENTISTS (FORMS AND FEES) (AMENDMENT) RULES, 2015

1. These Rules may be cited as the Medical Practitioners and Dentists (Forms and Fees) (Amendment) Rules, 2015.

2. The Medical Practitioners and Dentists (Forms and Fees) Rules, 1979, are amended in the First Schedule—

(a) by deleting Forms II, IV, V, VI, and XI and substituting therefor the new Forms as set out in the First Schedule hereto;

(b) by deleting the expression “section 5” appearing in Form X and substituting therefor the expression “rule 5”;

(c) by adding the new forms set out in the Second Schedule hereto immediately after Form XV—

FIRST SCHEDULE

FORM II

PHOTO

THE MEDICAL PRACTITIONERS AND DENTISTS ACT

(Cap. 253)

APPLICATION FOR PERMANENT REGISTRATION AS A MEDICAL OR DENTAL PRACTITIONER

1. Surname ..................... First Name ..................... Other Names .....................

2. Date of Birth .................................. Nationality ..................................

3. ID No./Passport No. ......................................................................................

4. Address ............... Code ......... Town ............ County .......... Cell Phone .............

5. Email ..............................................................................................................

6. Degree, Diploma or licence held. .................................. Date(s) qualified ..................

7. Name of medical/dental school .................................. Email ............................
8. Name of Internship Training Centre .............................................................. Email ............................................................... 
   Period of internship from .............................................................. to ............................................................... 

9. Particulars and testimonials covering the period of experience .............................. 

10. Name of employer ............................................................................................... 
    Address ................................................................................................................... 
    Code ...................................................................................................................... 
    Town ...................................................................................................................... 
    County .................................................................................................................. 
    Email ................................................................................................................... 
    Tel ......................................................................................................................... 

Requirements: 

(i) Copy of ID/Passport; 
(ii) Coloured passport size photo; 
(iii) Certified copies of professional & academic certificates; 
(iv) Evidence of passing Board’s pre-registration examination; 
(v) Internship completion Assessment Forms duly filled and stamped; 
(vi) Evidence of registration from EAC Partner States’ Boards and councils (for those applying for reciprocal registration); 
(vii) Registration Fee KSh. 8,000.00 

All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643 Milimani Branch. SWIFT CODE: KCBLKENX, BANK: KCB, BANK CODE: 01175. 

I hereby certify that the above information is correct to the best of my knowledge and that I have met the above requirements. 

Signature of Applicant: .............................................................. Date 

FOR OFFICIAL USE 

The process will take a maximum of two weeks. 

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<th>PREPARED:</th>
<th>APPROVED/NOT APPROVED</th>
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<td>RECOMMENDED:</td>
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FORM IV A

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)

APPLICATION FOR MEDICAL AND DENTAL PRACTITIONERS INTERNSHIP LICENCE

1. Surname .................................. First name .................................. Other names ...............

2. Date of Birth .................................. Nationality ..................................

3. Address .................................. Code .................................. Town .................................. Tel. ...........................

4. Degree, Diploma or Licence held (if degree not in English provide official translation) .............................................. ...........................

5. Name of Medical/Dental School .................................. Address .................................. Code ..................................

6. Name of Internship Training Centre .................................. Address .................................. Code ...............................

Requirements:

(i) Copy of ID/Passport;

(ii) Coloured passport size photograph;

(iii) Evidence of passing Board Internship Qualifying Exam (foreign trained);

(iv) Copy of posting letter from the Ministry of Health;

(v) Evidence of completing Medical/Dental Training in an accredited University in Kenya;

(vi) Evidence of having completed Medical/Dental Training in an institution within the EAC that qualifies for reciprocal recognition;

(vii) Licence fee KSh. 5000.

I hereby certify that the above information is correct to the best of my knowledge and I have met the above requirements.

Signature of applicant .................................. Date ..........................

FOR OFFICIAL USE:

The process takes a maximum of two (2) weeks

PREPARED BY:

Name: .................................. Designation: ..........................

Signature: .......................... Date ..................................

APPROVED/NOT APPROVED

Name: ..........................

Designation: ..........................
FORM IV B

THE MEDICAL PRACTITIONERS AND DENTISTS ACT

(Cap. 253)

THE MEDICAL PRACTITIONERS AND DENTISTS BOARD

INTERNSHIP LICENCE FOR MEDICAL AND DENTAL PRACTITIONERS

Dr. ......................................................................................................

(full name)

of ..................................................................................................

(address)

Qualifications ...................................................................................

Is hereby licensed by the Medical Practitioners and Dentists Board to render Medical

services at ..........................................................................................

(name of approved institution)

In accordance with the provisions of section 13 of the Act.

Dated the ................................................., 20 .......................................

Registrar

Medical Practitioners and Dentists Board

CONDITIONS OF LICENCE:

1. This licence is valid for a period of 11 MONTHS from the date hereof.

2. This licence is authorized to render medical or dental services as the case may be

   only at the institution mentioned in this licence.

3. The licence is entitled to engage in training employment.

4. This licence does not entitle you to engage in private practice.

5. Signature of Holder ..............................................................................
FORM V A

THE MEDICAL PRACTITIONERS AND DENTISTS BOARD

APPLICATION FOR RETENTION IN THE YEAR..................................REGISTER

(ALL DOCTORS)

(All fields are mandatory)

1. Surname .................................. Other Names ..............................................
   Reg. No..................................

2. Date of Birth .................................. Nationality ..........................................

3. Address.................................. Code .................................. Town ............... Mobile No..................

4. Email ...............................................................................................

5. Name of Employer .................. Address .............. Code ......... Town .............
   Email................................................................................................

6. Work station .................. County .................. Sub-County ..................

7. Basic Qualifications .......................... Postgraduate qualifications ..................................

8. Recognized Speciality .................. Sub Specialty ..........................

Requirements:

(a) Acquire a minimum of 50 CPD points in the calendar year

(b) Evidence of employment if practitioner is not in private practice

(c) Renewal fee Kshs.4,000

All payments should be made to:
Medical Practitioners and Dentists Board
Account No: 1103158643,
Bank: KCB, Milimani Branch.
SWIFT CODE: KCBLKENX
BANK CODE: 01175

*Transactions can be undertaken at any KCB Branch countrywide

(d) Late payment will attract 50% penalty. Penalty date is 30th September ..........

Computer generated and stamped banking slip together with should be, within the first
week, either emailed to info@kenyamedicalboard.org or posted to Medical Practitioners
and Dentists Board Office.

I hereby certify that the above information is correct to the best of my knowledge and I
have fulfilled all the above requirements.

Signature ........................................ Date ........................................
FORM V B

THE MEDICAL PRACTITIONERS AND DENTISTS BOARD

ANNUAL RETENTION CERTIFICATE

Date of first registration (date) Registration No. (Reg. No.)

This is to certify that ...........................................................................................................

Whose qualifications are: (Qualifications)

And whose registered address is: (Address)

Having duly complied with the provisions of the Medical Practitioners and Dentists Board is entitled to practice during the year (year).

A retention certificate must be renewed for very subsequent year. This confirmation is evidence of retention in the Register only until 1st December (year).

This certificate does not allow the holder to engage in Private practice.

Seal of the Board.

Dated ........................................ 20......

(Signature)........................................ (DMS)........................................................

Registrar, Medical Practitioners and Dentists Board.
THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)
APPLICATION FOR REGISTRATION OF A PRIVATE MEDICAL INSTITUTION

PART I
(To be completed by the applicant in duplicate)

1. CONTACT DETAILS OF THE PROPOSED INSTITUTION
(Block Letters)
(a) Name of the Institution........................... Address.................................
(b) Telephone Number............................... Mobile.................................
(c) Email .....................................................

2. TYPE (State whether Hospital, Nursing Home, Maternity Home, Health Centre, Dispensary, Laboratory, etc.).

3. LOCATION OF THE INSTITUTION
(a) Town/Centre/Market.................................................................
(b) Location.................................................................
(c) County.................................................................

PART II
(To be completed by the applicant in duplicate)

1. FULL NAMES AND ADDRESS OF THE APPLICANT
(Block Letters)

STATE IF APPLICANT IS A DIRECTOR AND/OR ADMINISTRATOR OF THE INSTITUTION

* Delete where inapplicable

2. NATIONALITY OF THE APPLICANT

3. PLACE AND DATE OF BIRTH...........................................................

4. NATIONAL IDENTITY CARD No.....................................................
(Attach Photocopy)
5. PASSPORT No. (if applicable) .................................................................
   ADDRESS ..................................................................................................................

6. WORK PERMIT No. (if applicable)
   ....................................................................................................................................
   (Attach documentary evidence- copies only).

PART III

(To be completed by the applicant in duplicate)

Give full names of Directors of the institution including the following: Nationalities, Passport
Numbers, Work Permit Numbers, Email Address, Kenya National Identity Card Numbers, etc

(Attach copies of documentary evidence).

(i) ....................................................................................................................................

(ii) ....................................................................................................................................

(iii) ....................................................................................................................................

(Use extra space if necessary).

PART IV

(To be completed by the applicant in duplicate)

1. Give full names and registration number of the medical or dental practitioner who
   shall be in-charge of the patient health care at the proposed institution:
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

2. (a) Give full details of professional qualifications of the person named at paragraph
   (1) above. Include year and place where obtained;
   (b) State work experience of the person named at paragraph (1) of PART IV above
   and name institutions where obtained and date;
   (c) Attach documentary evidence (photocopies) in each case. (Please use extra
   space if necessary).
   ........................................................................................................................................

3. (a) Give full names and professional qualifications of any other person(s), identified
   by your institution to undertake patient health care at the institution(e.g., Clinical
   Officers, Nurses, Laboratory Technicians, X-ray Staff, Doctors, Technicians,
   Pharmaceutical Technicians, etc.).
(b) Attach documentary evidence (photocopies) in each case. (Please use extra space if necessary).

(i) ..........................................................................................................
(ii) ..........................................................................................................
(iii) ..........................................................................................................
(iv) ..........................................................................................................
(v) ............................................................................................................
(vi) ..........................................................................................................

PART V

(To be completed by Medical Officer of Health in duplicate)

INSPECTION REPORT FOR PRIVATE MEDICAL INSTITUTIONS - FOR REGISTRATION PURPOSES

1. NAME OF THE INSTITUTION ...........................................................................

2. PHYSICAL LOCATION

(a) Plot No./L.R. No. .........................................................................................
(b) Market/Centre/Town* ...................................................................................
(c) Street / Road ..................................................................................................
(d) Location ...........................................................................................................
(e) County ..........................................................................................................

3. PREMISES GENERAL INFORMATION

(a) Plot area (in hectares) ..................................................................................
(b) Water supply ...............................................................................................adequate/inadequate* (*Delete where inapplicable)
(c) Refuse disposal:
   (i) Incinerator available/Not available.*
   (ii) Other modes of refuse disposal (Specify)

...........................................................................................................................
...........................................................................................................................
...........................................................................................................................
(d) Environmental suitability .............................................................................recommended/not recommended.

* State reasons for not recommending:
...........................................................................................................................
...........................................................................................................................
4. PLAN OF THE INSTITUTION

(a) Approved/ No approved* by the local District Development Committee (attach copy of the plan) and documentary evidence (copies) of approval of the institution by the D.D.C

5. OUT-PATIENT SERVICES

(See attached minimum requirements for General Practice).

(a) Waiting Bay/ Reception Area/Room: *

(i) Seating capacity.................................................................

(ii) Area (in square metres)......................................................

(iii) Construction ............................................................. Covered/ Not Covered. *

(b) Examination Rooms:

(i) Number of rooms.................................................................

(ii) State if equipment inspected meets the minimum requirements. Attach separate signed list of equipment inspected if necessary.

(c) Treatment room:

(i) Number of rooms.................................................................

(ii) State if equipment meets the minimum requirements. Attach separate signed list of equipment inspected.

(*Delete where inapplicable)

6. IN-PATIENT SERVICES

(a) Female Ward:

(i) Size of the ward (in square metres)...........................................

(ii) Number of beds.................................................................

(iii) Number of toilets.............................................................

(iv) Number of bathrooms........................................................

(v) Number of sluice rooms.....................................................

(b) Male Ward:

(i) Size of the ward (in square metres)...........................................

(ii) Number of beds.................................................................

(iii) Number of toilets.............................................................

(iv) Number of bathrooms........................................................

(v) Number of sluice rooms.....................................................
(c) Maternity Ward:
   (i) Size of the ward (in square metres).
   (ii) Number of beds.
   (iii) Number of toilets.
   (iv) Number of bathrooms.
   (v) Number of sluice rooms.
   (vi) Placenta pit depth (in metres).

(d) Paediatric Ward:
   (i) Size of the ward (in square metres).
   (ii) Number of beds.
   (iii) Number of toilets.
   (iv) Number of bathrooms.
   (v) Number of sluice rooms.

7. CLINICAL SUPPORT SERVICES

(a) Pharmacy:
   (i) Area of the waiting room (in square metres).
   (ii) Number of dispensing windows.
   (iii) Number of antibiotic (safe cupboards).
   (iv) Number of drug stores.

(b) Laboratory:
   (see attached minimum requirements)
   (i) Reception area (in square metres).
   (ii) Seating capacity.
   (iii) Size of work-room (in square metres).
   (iv) Equipment (attach a separate signed list of equipment and reagents/chemicals inspected).

(c) X-ray Unit:
   (See attached minimum requirements).
   (i) Size of the reception area (in square metres).
   (ii) Seating capacity.
   (iii) Number of screening rooms.
   (iv) Standard of radiation protection.

   Adequate/Not Adequate.

   (v) Equipment (attach separate signed list of equipment inspected).
(d) Operating Theatre:

(i) Minor theatre equipment (attach separate signed list of equipment inspected).

(ii) Major theatre (indicate by a tick or cross in the box next to the item to show whether available or not).

Induction room............................................ □
Operating room............................................ □
Recovery room............................................ □

Lighting.......................................................... (Adequate/Not Adequate).*
Equipment..................................................... (attach separate signed list of equipment inspected).

8. OTHER SUPPORTING SERVICES

(a) Kitchen;

(i) Cooking facility (specify)................................................................. (Adequate/Not Adequate).*

(ii) Non-Perishable store......................................................... (Adequate/Not Adequate).*

(iii) Perishable store................................................................. (Adequate/Not Adequate).*

(b) Laundry Type (specify).................................................................

(c) Mortuary:

(i) Available/ Not Available.*

(ii) Refrigerated/ Not refrigerated.*

(iii) Appropriately located /Not appropriately located.*

(If not appropriately located, state why)

(iv) Body capacity..........................................................................

(v) Adequate privacy /Not adequate privacy.*

(vi) Number of ambulances.................................................................

(vii) Other facility (specify and use extra space if necessary)..................................

(* Delete where inapplicable)

PART VI

(To be completed by the Medical Officer of Health in duplicate)

1. Give full names and designations of members of the D.H.M.T who participated in the inspection of the institution.

<table>
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<th>NAME</th>
<th>DESIGNATION</th>
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</table>
2. CERTIFICATE BY M.O.H

I, Dr. ..............................................................................................................................
(State full names in Block Letters)

being the Medical Officer of Health in .................................................................

County, do hereby certify that the inspection of ..............................................................
was conducted by the County Health Management Team of ........................................ on 
................................................day of..................................................20 ...........
under my personal supervision.

I further certify that the inspection was witnessed by

Dr./Mr./Mrs./Miss .................................................................................. being the 
Owner/Director/Applicant * and that ........................................... o .........................................
the said institution does/does not* meet the minimum requirements for 
Registration/Licensing purposes.

Dated this .................................................. day of ................................... 20 ..........................

Signature..............................................................................................
(Medical Officer of Health)

Name of Station ....................................................................................................................

Address................................................................................................................................

TelephoneNumber ................................................

(* Delete where inapplicable)

PART VII

(To be completed by the Applicant/ Director/ Owner of the institution in duplicate)

I, Dr. /Mr. /Mrs. /Miss * ..............................................................................
(Full Names in Block Letters)

hereby certify that all the information given by me in the application form is true and 
correct and that I personally witnessed the inspection which was conducted by the 
Medical Officer of Health on 
................................................day of ................................................ . 20....... 

Signature..............................................................................................

Name in Full..............................................................................................
APPLICANT TO NOTE:

This form MUST be returned to the Medical Practitioners and Dentists Board within a period not exceeding three months from the date of issue. Applications which are not returned within the stipulated period shall be time barred.

PART VIII

(For the purposes of vetting applications and enforcement of Laws, Regulations and Decisions of the I.R.C. and the Board.)

(a) Name of the institution acceptable to the IRC .................................................................

(b) Type of institution............................................................................................................

(c) Give Name, Type, Location and Registration Number of other institutions operated by
the Applicant/ Director or affiliated to the institution named in this application:
   (i) ........................................................................................................................................
   (ii) ........................................................................................................................................
   (iii) ........................................................................................................................................
   (iv) ........................................................................................................................................

   (Use extra space if necessary).

* Delete where inapplicable

(d) Give full particulars of criminal court proceedings for violations of any of the following Ministry of Health laws by any of the institution named in paragraph (c) in this application(Cap. 253, Cap. 260, Cap. 257, Cap 244, Cap 245, Cap. 254 and Cap. 242 (Quote court case references in each case for the past three years proceeding the date of this application)

..................................................................................................................................................

..................................................................................................................................................

(Use extra space if necessary).

(e) Give names of institutions, their location and registration numbers from among those
named at paragraph (c) in this application which have defaulted in licence fees payment during the past three years. State each year of default and penalty imposed and whether or not / penalty has been paid and fees recovered:

..................................................................................................................................................

..................................................................................................................................................

(Use extra space if necessary).

(f) Give names of any of the institutions named at paragraph (c) in this application
which the Board has authorized closure during the past three years (quote minutes
references of the I.R.C. and state the institutions' registration number and place of location).

..................................................................................................................................................

..................................................................................................................................................

(Use extra space if necessary).
(g) F.R.L. Serial No. and date of this application

(h) Licence Fees Category (quote I.R.C. minutes reference)

(i) F.R.L. Receipt No. and Date

(j) Date application returned to applicant

(k) Date application re-submitted by applicant

(l) Registration Fees Receipt No. and Date

CERTIFICATE BY AN OFFICER AUTHORIZED FOR THE PURPOSES OF PART VIII OF THIS APPLICATION

(This certificate must be countersigned by the Registrar)

I certify that the institution for which this application is made and its Owner/Director/Applicant or its Administrator has/has not been subject to the criminal proceedings in violation of any of the laws named in Paragraph (d) in this application and that all information given under PART VIII of this application is correct and true.

Dated this day of , 20

Authorized Officer

PART IX

FOR OFFICIAL USE ONLY

1. INSTITUTION REGISTRATION COMMITTEE'S RECOMMENDATIONS

Dated this day of , 20

Chairman
Medical Practitioners and Dentists Board

Chairman, Committee

* Delete where inapplicable
2. INSTRUCTIONS TO THE REGISTRAR BY THE BOARD

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Dated this........................................ day of ................................................... 20............

Chairman,
Medical Practitioners and Dentists Board

--------------------------------------------------------------
FORM VIA
PHOTO

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)
APPLICATION FOR RECOGNITION OF SPECIALIST/SUB-SPECIALITY STATUS

1. Surname ..................... Other Names .................. Reg. No. .....................

2. Date of Birth ..................... Nationality .....................

3. Address ..................... Code ..................... Town ..................... Cell Phone .....................

Email .....................

4. Employer .....................

5. Degree, Diploma or Licence held (give name of medical school and date qualified).....................

6. Specialty/sub speciality applied for .....................

7. Postgraduate qualifications: medical/dental school .....................

Date qualified .....................

8. Number of years of experience in speciality/sub speciality after obtaining postgraduate qualifications (indicate the number of years or months, name of institution(s) attended and name of two supervisors whose address must accompany this application).

No. of Years/Months .............. Name of Institution .............. Country ..............

Supervisors: (a) Name ..................... Address .............. Code .....................

Email ..................... Telephone: .....................

(b) Name ..................... Address .............. Code .....................

Email ..................... Telephone: .....................
Requirements:

(i) Copy of post graduate qualifications and official transcripts;
(ii) Evidence of completion of 2 year full time rotation in a recognized institution for specialist recognition;
(iii) Supportive recommendation from two (2) supervisors in the relevant field;
(iv) For sub-speciality recognition, the applicant should show evidence of training for at least one year;
(v) Specialty and sub-speciality must be in the gazetted list;
(vi) Application fee - KSh. 20,000.00

All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643, Milimani Branch.

I hereby certify that the above information is correct to the best of my knowledge and that I have met all the above requirements.

Signature of Applicant: ___________________________ Date: ___________________________

FOR OFFICIAL USE:

This process takes a maximum of two (2) weeks.

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<td>Specialty/SubSpecialty: ...........</td>
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THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)

APPLICATION FOR PRE-REGISTRATION EXAMINATION

1. Surname: .................................. Other Names: ..................................
2. Date of Birth: .................................. Nationality: ..................................
3. Address: .................................. Code: .......................... Town: .................................. Tel: ..................................
   Email: .................................. Mobile: ..................................
4. Degree, Diploma or Licence held (give name of medical school and date qualified – if degree not in English, provide official translation).

5. Particulars of Experience (e.g. posts held, type of practice in which the applicant has been engaged, countries in which the applicant has practiced):

6. Testimonials Covering the Period(s) of Experience

7. Have any arrangements been made regarding employment? (if so, give details) ..........................................................

Requirements:

(i) Copy of ID/Passport;

(ii) Coloured passport size photograph;

(iii) Certified copies of professional certificates;

(iv) Evidence of appropriate linguistic skills in English and/or Kiswahili for non-Kenyon;

(v) Academic transcripts or evidence of internship;

(vi) Curriculum Vitae;

(vii) Must be attached at a training institution approved by the Board for a period of four (4) months;

(viii) Evidence of completion of internship or registration from a Medical Council;

(ix) Evidence of employment/job offer in a recognized institution;

(x) Letter from Commission for Higher Education (CHE) confirming recognition of the medical/dental school (if foreign trained);

(xi) Qualification (Form IV or VI certificates);

(xii) Application fee KSh. 5,000.00;

(xiii) Examination/evaluation of qualification papers - Fees KSh. 50,000.00.

All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643, Milimani Branch.

Signature of applicant
........................................................................................................

FOR OFFICIAL USE:

<table>
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SECOND SCHEDULE

FORM XVI

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)

APPLICATION FOR PEER REVIEW

1. Surname ........................................ Other Names ........................................

2. Date of Birth ................................... Nationality ...................................

3. Address ......................................... Code ........................................ Town ...................................... Tel/Mobile ..................................

   Email ........................................

4. Degree, Diploma or Licence held (give name of medical school and date qualified – if degree not in English, provide official translation)

5. Particulars of Experience (e.g. posts held, type of practice in which the applicant has been engaged, countries in which the applicant has practiced)

6. Testimonials Covering the Period(s) of Experience ........................................

7. Have any arrangements been made regarding employment? (if so, give details) .........

Requirements:

(i) Copy of ID/Passport;

(ii) Coloured passport size photograph;

(iii) Certified copies of professional certificates and academic transcripts;

(iv) Copy of current CV;

(v) Evidence of postgraduate qualification(s);

(vi) Certificate of status from current regulatory authority;

(vii) Specialist Recognition (if any) from current medical Board;

(viii) Application fees of Kshs. 5,000.00;

(ix) Peer Review/evaluation fees of Kshs. 95,000.00.

All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643, Milimani Branch; SWIFT CODE: KCBK KenX, BANK CODE: 01175, BANK: KCB
I hereby certify that the above information is correct to the best of my knowledge and I have fulfilled all the above requirements.

Signature of applicant ........................................ Date........................................

FOR OFFICIAL USE:

The process takes a maximum of Thirty (30) days

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FORM XVII

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)

RENEWAL FORM FOR PRIVATE PRACTICE LICENCE 20....

(All fields are mandatory)

1. Surname .................................. Other Names .................................. Reg. No. ............
2. Date of Birth .................................. Nationality ..................................
3. Address .................................. Code .................................. Town .................. Mobile No. ............
   Email ..................................
4. Employer ..................................
5. Name of authorized premises .................. County .................. Sub county ............
6. Previous Private Practice Licence Number ..................................
7. Notification for any changes of name, address and/or authorized premises ..............
   ...................................
8. Specialist/General practice. If specialized please specify the discipline ..........
   Sub Specialty ..................................
9. Letter of no objection from employer/Schedule of duties should be provided for Part-time practice.
10. All applications together with payments should be received by 30th September, 20......
11. Late payment shall attract 50% penalty.
Requirements:

(i) Fees:

Kenyans—

A fee of Shs.15,000 is payable annually for Specialist Practice
A fee of Shs.10,000 is payable annually for General Practice
A fee of Shs.10,000 is payable annually for Part-time Practice

Non-Kenyans—

A fee of Shs.40,000 is payable annually for Specialist Practice
A fee of Shs.30,000 is payable annually for General Practice
A fee of Shs.30,000 is payable annually for Part-time Practice

(ii) Copy of previous licence;

(iii) Acquire a minimum of 50 CPD points.

All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643, Milimani Branch.

Computer generated and stamped banking slip together with renewal form should be, within the first week, either emailed to or posted to the address below.

Signature of applicant ............................................. date...........................

I hereby certify that the above information is correct to the best of my knowledge.

FOR OFFICIAL USE:

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Physical Address: MP&DB House- Woodlands Rd off Lenana Rd
Tel: +254 20-272 8752 +254 20 272 4994 +254 20 271 1478
Mobile: +254 720 771 478 +254 736 771 478
Address: P.O Box 44839-00100, NAIROBI-Kenya

Email: info@kenyamedicalboard.org
Website: www.medicalboard.co.ke
THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)
APPLICATION FOR TEMPORARY LICENCE FOR FOREIGN DOCTORS

1. Surname .................................. Other Names ..................................

2. Date of Birth .................................. Nationality ..........................

3. Address .................................. Code .......................... Town ............... Tel ..............

4. Degree, Diploma or Licence held (if not in English, provide official translation)
............................................................................................................

5. Name of medical/dental school ..................... Dates qualified ..................

6. Particulars of Experience (e.g. posts held, type of practice in which the applicant has been engaged, countries in which the applicant has practiced):
............................................................................................................

7. Testimonials covering the period of experience
............................................................................................................

8. Name of employer: ....................... address .................. Code ..........................

Email .................................. Tel No ...................................................

9. Is this a New Application or a Renewal? .......... If renewal, licence No..........................

Mandatory Requirements:
(i) Copy of ID/Passport;
(ii) Current coloured passport size photograph;
(iii) Certified copies of professional certificates and transcripts;
(iv) Certificate of Status;
(v) Introduction letter/job offer from the institution;
(vi) Copy of registration certificate from respective medical Board/Council;
(vii) Copy of current/last practice licence;
(viii) Copy of current CV;
(ix) Licence fee Kshs.20,000.00.

All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643, Milimani Branch.

I hereby certify that the above information is correct to the best of my knowledge and I have met the above requirements.

Signature of applicant .................................. Date ..........................
FORM XIX

THE MEDICAL PRACTITIONERS AND DENTISTS BOARD
(The Medical Practitioners and Dentist Act, Cap. 253)
TEMPORARY LICENCE FOR FOREIGN DOCTORS

Dr. ........................................................................................................
(full name)
of ........................................................................................................
(address)
Qualifications ..........................................................................................

Is hereby licensed by the Medical Practitioners and Dentists Board to render Medical
services at ..................................................................................................
(name of approved institution)
In accordance with the provisions of section 13 of the Act.
Dated the ........................................... 20 ......................

Registrar
Medical Practitioners and Dentists Board

CONDITIONS OF LICENCE:
1. This licence is valid for a period of 9 MONTHS from the date hereof.
2. This licence is authorized to render medical or dental services as the case may be
only at the institution mentioned in this licence.
3. The licence is entitled to engage in training employment.
4. This licence does not entitle you to engage in private practice.
5. Signature of Holder .............................................................................
FORM XX

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)

APPLICATION FOR CERTIFICATE OF STATUS

SECTION A: PERSONAL DETAILS

1. Surname ......................... Other Names ..................... Reg. No. ..............
2. Date of Birth ..................... Nationality .......................
3. Address ..................... Code ............... Town ......... Tel/Mobile ..............
   Email............................................................................................
4. Reasons for Certificate of status ...............................................................
5. Intended county of stay/study/practice ......................... Institution ..................
   Period.............................................................................................
6. If certificate is for travel, when are you expected back into the country ...................

SECTION B: REFEREE

I, Dr./Prof. (Names in full) ...........................................................................
(indicate Full Names as they appear in the Register)
Reg. No ........................................ of P.O. Box ..........................................
Telephone (Mobile) ................................... Email ..........................................

Being a practitioner of good standing, I do hereby declare that I have been and I am well acquainted with the said Dr ...........................................................................
Reg. No./Licence No ...................................................................................

For the past ......................... years; and further declare that during this time he/she:-
(a) has been engaged in Medical/Dental practice;
(b) has conducted himself/herself well socially and in a responsible manner;
(c) character and conduct have been ................................................................
(d) reasons for certificate of status ................................................................

Signed........................................... Date ....................................................

SECTION C: REQUIREMENTS

(i) A recommendation by a registered practitioner of good status (in section B above);
(ii) Attach copy of current retention certificate/private practice licence/temporary licence for foreign practitioner;
(iii) Evidence that the practitioner is not under any investigation by the Board;
(iv) Application fee of Kshs.20,000.00.
All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643, Milimani Branch; SWIFT CODE: KCBLKENX, BANK CODE: 01175, BANK: KCB

I hereby certify that the above information is correct to the best of my knowledge and that I have met all the requirements.

Signature of Applicant........................................Date...................................

FOR OFFICIAL USE:
The process takes a maximum of two (2) weeks.

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FORM XXI

THE MEDICAL PRACTITIONERS AND DENTISTS BOARD
APPLICATION FOR ACCREDITATION AS A CPD PROVIDER

PLEASE READ THIS SECTION CAREFULLY BEFORE COMPLETING THE FORM

(a) The application form must be completed by a duly authorized person;
(b) Every application must be accompanied by:-
   (i) an application fee of Ksh.15,000.00 (non-refundable);
   (ii) calendar of activities; and
   (iii) names of two referees.

All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643, Milimani Branch.

PART A: ADMINISTRATIVE INFORMATION

1. Particulars of Applicant

   (a) Name of institution:

   (b) Permanent Address:
(c) Physical Address:

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<th>(d) City/Town:</th>
<th>(e) County:</th>
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<td>(g) Postal Code:</td>
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<td>(h) Plot No.:</td>
<td>(i) LR No.:</td>
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<td>(j) Telephone No:</td>
<td>(k) Mobile No.:</td>
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<td>(l) Email:</td>
<td>(m) Website:</td>
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(n) Fax:

2. Name of Contact Person:

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Any other additional information:

PART B: DECLARATION BY APPLICANT

I, the undersigned confirm that all the information in this form and accompanying documentation is correct and true to the best of my knowledge. I further agree to inform the MPDB, about any changes or modifications made to the information given in the document(s) submitted.

Name of Head of Institution/Department: ..........................................................

Signature: ...............................................................................................

Name of CPD coordinator: ...........................................................................

Signature: ................................................................................................

Date of Application: ....................................................................................

Official Stamp:

PART C: FOR MPDB OFFICIAL USE ONLY

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FORM XXII
THE MEDICAL PRACTITIONERS AND DENTISTS BOARD
CPD ANNUAL RETENTION FORM
PART I

Name of Provider.................................................................
Telephone (landline)............................................................
Address................................................................................
Physical location.................................................................
Website................................................................................
Name of Contact Person......................................................
Position..............................................................................
Telephone...........................................................................
Email...................................................................................
Name & Signature of applicant..............................................
Date......................................................................................
I hereby certify that the above information is correct to the best of my knowledge.

FOR OFFICIAL USE:

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Tel: +254 20-272 8752 l+254 20 272 4994 l+254 20 271 1478
Mobile: +254 720 771 478 l+254 736 771 478
Address: P.O Box 44889-00100, NAIROBI-Kenya

Email: medicalboard@kenyamedicalboard.org
ceo@kenyamedicalboard.org
Website: www.medicalboard.co.ke
PART II

1. Part I provides information and guidelines for filling this form.

2. Part II will contain details of the CPD accredited provider. A copy of the Boards certificate should be attached.

3. Part III relates to the calendar of events. Applicants are expected to provide a detailed annual calendar of events in as much as possible the format indicated. The calendar of events should be received by the Board not later than 31st December of the preceding year.

4. Part IV will contain information of the attendees. Providers are expected to keep a record of the attendees of each activity in the prescribed form. The list of attendees should be received by the Board not later than thirty days from the date on which the activity was held.

5. A fee of Kshs 40,000/= to be paid per calendar year.

6. An application for retention shall be deemed to be for the next calendar year and can only relate to future CPD activities to be conducted.

7. CPD providers who intend to charge participants a fee shall indicate the same on the retention form and shall provide all relevant details of the same.

8. CPD programs or activities must-
   (a) have significant intellectual and practical content and should emphasize ethical aspects of practice;
   (b) be related to or be relevant to the practice of medicine;
   (c) be of relevance and benefit to medical practitioners, dental practitioners or other health professionals, or designed specifically for registered medical institutions (whether government or private);
   (d) be designed with the primary objective of increasing the professional competence of the attendee; and
   (e) be approved by the Board.

9. The Board’s decision shall be final.

--------------------------
FORM XXIII

PHOTO

THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)

APPLICATION FOR INTERNSHIP QUALIFYING EXAMINATION/FOR FOREIGN TRAINED DOCTORS/EAST AFRICA COMMUNITY RECIPROCAL RECOGNITION

1. Surname ..................................... Other Names ..................................

2. Date of Birth .......................... Nationality .....................................
3. Address........................Code........................Town........................Tel...........................

Email........................................................................................................................................

4. Degree, Diploma or Licence held (give name of medical school and date qualified if degree not in English, provide official translation)

Requirements:

(i) Copy of ID/Passport;
(ii) Coloured passport size photograph;
(iii) Certified copies of professional certificates;
(iv) Curriculum Vitae;
(v) Must be attached at a training institution approved by the Board for a period of four (4) Months;
(vi) Qualifications (Form IV or VI Certificates);
(vii) Evidence of appropriate linguistic skills in English and/or Kiswahili for non-Kenyans;
(viii) Evidence of registration from EAC Partner States Board’s and councils (for those applying for reciprocal registration);
(ix) Letter from Commission for Higher Education (CHE) confirming recognition of the medical/dental school (if foreign trained);
(x) Application fee Kshs. 5,000.00;
(xi) Examination/Evaluation of qualification papers Kshs.30,000.00.

All payments should be made at any KCB Branch countrywide to Board’s account No. 1103158643, Milimani Branch.

I hereby certify that the above information is correct to the best of my knowledge and I have fulfilled all the above requirements.

Signature...........................................Date..................................................

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Dated the 16th June, 2015.

JAMES MACHARIA,
Cabinet Secretary for Health.