

**MEDICAL COUNCIL OF TANGANYIKA**  
(Communications to be addressed to **THE REGISTRAR**)

Tel. 255-022-2120261-7 Ext.1721  
Direct Line: 255 22 2112673  
Fax: 255-22 2112731  
Email: [medicalcouncil@moh.go.tz](mailto:medicalcouncil@moh.go.tz)

Office of the Registrar  
P. O. Box 9083  
**DAR ES SALAAM**  
**TANZANIA**

**APPLICATION FOR A LICENSE TO PRACTICE**  
(Under S. 19 of the Medical Practitioners and Dentists Ordinance, Cap. 409 of the Laws)

**PART I**

(To be completed by the Applicant)

1. **NAMES:**  
Last Name:.....  
  
First Names:.....  
  
Middle Names: .....
2. **Date of Birth:** .....
3. **Nationality:** .....
4. **Address:** .....  
.....  
.....  
Tel. No. ....
5. **Name and address of your employer: (if self employed please state)**  
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.....  
Duty Station .....  
.....
6. **Qualification:** .....
7. **Awarding Authority/College/University**.....  
.....
8. **Year of award**.....

I hereby apply for a license to practice as an Assistant Medical officer/Dental officer.

.....  
**Signature of Applicant**

.....  
**Date**

***This form is to be submitted with the following:-***

1. Certified copy of qualifying diploma/degree
2. Certificate of good standing or letter of recommendation from the RMO/DMO/Head of Institution of Practice.
3. Curriculum Vitae
4. One passport size photograph
5. A non-refundable application fee of Tshs. 20,000/= payable to Medical Council of Tanganyika, Account Number **2041100008**, National Microfinance Bank (NMB) Kariakoo Branch.

**Note:** Documents which are not in English Language must be interpreted by a recognized authority and attached to the documents of the original language.

**PART II**

**(FOR OFFICIAL USE ONLY)**

**DECISION:**

This application has been approved/rejected for the following reasons:-

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**Signature of Registrar**

.....  
**Date**