Comhairle na nDochtúirí Leighis
Medical Council

GRADUATES OF MEDICAL SCHOOLS LETTER - APPLICATION FORM

PLEASE COMPLETE BOX AND WRITE LEGIBLY IN BLOCK CAPITALS

REGISTRATION NUMBER								
DATE OF BIRTH	D	D	M	M	Y	Y	Y	
MOTHER'S MAIDEN NAME FOR SECURITY REASONS								
SURNAME								
FORENAME								
EMAIL ADDRESS								
CURRENT REGISTERED ADDRESS								
ADDRESS TO WHICH DOCUMENTATION SHOULD BE SENT (IF DIFFERENT FROM ABOVE)								
For Office Use Only: Applicant is compliant based on list of approved Medical Schools Y / N								

IMPORTANT:

Unless otherwise specified, a "Graduates of Medical Schools" letter will be issued to your **registered address** on completion of this request. If you have changed address since your original registration certificate was issued, you should update your address first. The cost of this letter of certification is **€65.**

Signed:_____ **Date:**_____

Please return the completed signed form to ***Medical Council, Kingram House, Kingram Place, Dublin 2*** or e-mail the form to ***registration@mcirl.ie***

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Medical Council

PAYMENT FORM

MEDICAL COUNCIL - FINANCE SECTION
KINGRAM HOUSE, KINGRAM PLACE, DUBLIN 2

REGISTRATION NO
SURNAME: **(BLOCK CAPITALS)**
FORENAMES: **(BLOCK CAPITALS)**
TELEPHONE NO:
EMAIL ADDRESS:
PLEASE STATE TYPE OF PAYMENT, (E.G.ANNUAL REGISTRATION FEE)**:**

METHOD OF PAYMENT:

- ☐ **DRAFT (Drawn on Irish Bank)**
- ☐ **VISA DEBIT CARD**
- ☐ **CREDIT CARD (MASTERCARD / VISA)**
- ☐ **LASER CARD**

Credit/Laser Card Payment

- **CCV number MUST be entered as failure to do so will result in application being delayed**.

Please debit my Visa / Mastercard / Laser card for the sum of €_____

VISA/ MASTERCARD NO.																Exp. Date				

CVV NO. (last 3 digits on back)			

Lasercard/ VisaDebit Card No.																			Exp. Date				

Name of Credit Card/Laser Holder (Complete in Block Capitals): _____

Signature:_____Date: _____

FOR OFFICE USE ONLY:

FEE TAKEN BY:_____DATE_____

[TO BE COMPLETED BY STAFF MEMBER PROCESSING APPLICATION]