Medical Council License Registration Form

Full Name:

Date of Birth:

Gender:

--Select--

Address:

Phone:

Email:

Medical Qualification(s):

e.g., MBBS, MD

University/Institution Name:

Year of Passing:

Previous Registration Number (if any):

Upload Documents:

(Certificates, identity proof, transcripts, etc. - upload as PDFs or JPGs) Choose File No file selected

Declaration:

I hereby declare that the information provided is true and correct to the best of my knowledge and belief. I Agree

Submit Application

Note: Ensure all details are filled accurately and supporting documents are attached for timely processing of your license application.