THE FIJI COLLEGE OF

GENERAL PRACTITIONERS

**Membership Information Form**

**Please fill in the form and return to:**

The Fiji College of General Practitioners

PO Box 14012, Suva

E: fcgpsec@gmail.com | T: 3371007

**Personal**

First Name Middle Name(s)

Last Name Gender M ☐ F ☐

Date of Birth (dd/mm/yyyy) Year entered General Practice

**Medical Council**

Registration # Practicing License Renewal Date (dd/mm/yyyy)

**Contacts**

Email Address

**Phone Contacts**

Mobile Home Work Fax

Work Address

Postal Address

**Qualifications**

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| --- | --- | --- | --- |
| Qualification Attained | Institution | Country | Year |
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**Place of Practice**

|  |  |
| --- | --- |
| Name of Practice |  |
| Physical Address |  |
| Phone |  | Fax |  |