



# MEDICAL BOARD OF WESTERN AUSTRALIA

ABN: 25 271 541 367

## APPLICATION TO REGISTER ADDITIONAL QUALIFICATION(S) AND TRANSFER TO THE CONDITIONAL REGISTRATION CATEGORY OF RECOGNISED SPECIALIST QUALIFICATIONS AND EXPERIENCE

Reg. No:

Trans. Date

New Reg No.

Fee Paid

Receipt No:

I,

(Full name in block letters - underline Surname)

of

wish to make application to the Board to transfer to the Conditional Registration category of **Recognised Specialist Qualifications and Experience** pursuant to Section 38 of the *Medical Practitioners Act 2008*.

I declare as follows:-

- |                                                                                                                                                                                                                                                                                      | YES                      | NO                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. I am registered under the <i>Medical Practitioners Act 2008</i>                                                                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I attach my <b>original</b> or <b>certified</b> <sup>†</sup> Australian Fellowship Certificate/letter from the relevant Australian College which I request be registered, and expressly declare that I am the person to whom such was granted and the person therein referred to. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I am still entitled to practice under the qualification by virtue of which I apply to be registered in the place where the same was granted.                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I attach the fee of \$30.00                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_  
*Signature of Applicant*

this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_

\_\_\_\_\_  
*Signature of Witness*

In support of the above Declaration I submit the following **ORIGINAL/CERTIFIED<sup>†</sup> COPY(IES)** of my Australian College Fellowship

	COLLEGE	YEAR
<b>FELLOWSHIP</b>		

**Certified Documents<sup>†</sup>** Documents can only be accepted if certified by a person described in section 12 (6) (a) – (c) of the *Oaths, Affidavits and Statutory Declarations Act 2005* or an authorised representative of the Registrar of the Medical Board of Western Australia. For further information, please refer to the Board's website – Registration Information.

### **PAYMENT BY CREDIT CARD (VISA OR MASTERCARD)**

<b>Name on Card</b>			
<b>Card number</b>	- - - - -		
	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<b>Expiry</b> /
<b>Signature of Cardholder:</b>			