FORM 11
(Regulation 24)
MEDICAL ACT 1971
(Section 20)
MEDICAL REGULATIONS 1974
APPLICATION FOR ANNUAL PRACTISING CERTIFICATE

1. Full name of applicant (as in Medical Register) .................................................................
   ........................................................................................................................................
2. Residential address ........................................................................................................
   ........................................................................................................................................
3. (a) Address of principal place of practice .................................................................
   ........................................................................................................................................
   (b) Addresses of other places of practice ................................................................
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................
4. (a) Full registration certificate No. (if any) .................................................................
   (b) Date of full registration or of registration under any previous law .................
   (c) Place of registration under any previous law ....................................................
   ........................................................................................................................................
5. Last Annual Practising Certificate No. .................................................................
6. Particulars of *Money Order/Cheque which is attached:
   (a) No.............................................. (b) Sum.............................................................
   (c) Post Office/Bank & date ......................................................................................

Date:.................................................. Signature of applicant

NOTES –
1. This application should be addressed and submitted to –
   THE REGISTRAR OF MEDICAL PRACTITIONER,
   MINISTRY OF HEALTH,
   LEVEL 2, BLOCK E1, PARCEL E
   FEDERAL GOVERNMENT ADMINISTRATIVE CENTRE
   FEDERAL TERITORY
   62518 PUTRAJAYA
   NOT later than the 1st day of December.

2. The fee payable is RM50.

3. Where the application is made later than the 1st day of December, a late fee of RM50 is payable.
[To be completed in the case of medical officers in the service of the Government or a State Government or any of the Universities in Malaysia]

I. (name)……………………………………………… (designation) …………………
………………………………………………………………………………………………

hereby certify that the abovenamed applicant is employed as a medical officer in (state the name of the service) …………………………………………………………………………… at (state place of service) ……………………………………………………………………………

Date……………………………………………………………………………………………

______________________________
Signature of Local Head of Department

For Official Use Only

A.P.C. No…………………………………………… issued on ……………………………

*Fee of RM50 paid vide receipt No. ………………………… dated ………………………

* Exempted from payment of fee under regulation 25.

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* Delete whichever is inapplicable

NOTE:
1. Please fill the form in block letter completely and please make a copy for use future;
2. Please write your name and Identity Card Number behind the Postal Order/Bank Draft/Cheque;
3. Practitioners who are NOT yet fully registered are not eligible to apply for APC;
4. Practitioners need NOT apply for APC until 31st December of the first year of full registration;
5. For Foreign Practitioners, please attach a copy of your full registration; and
6. Please submit a certified copy of your resignation letter if you have just resigned from the government.
ADDITIONAL INFORMATION:

1. Name: .................................................................................................................................

2. (a) Identity Card No.: New: ........................................... Old: ..............................................

   Color: ...................................................

   (b) Passport No. (for foreigner): .................................................................

3. Citizenship: Malaysian/If Others* (Please state): .................................................................

4. Date of Birth: ........../........./......... 5. Gender: Male/Female*


8. Telephone No. (Res.) ............................................... (H/P) .................................................................

9. Email address: .............................................................................................................................

10. Qualification of Medical Degree:

   10.1. Qualification: ...........................................................................................................................

   10.2. Institution granting the qualification: .........................................................................................

   10.3. Year obtaining the qualification: .............................................................................................

11. Type of practice: Sole-proprietor/Group/Government*

12. Total Place of Practice (if more than one place of practice): ......................places.

13. Practice Addresses and treatment times (please append attachment, if necessary):

   13.1. Address: .............................................................................................................................

       Day & Time: ............................................................................................................................

       Tel. No.: ......................... Fax No.: .........................

   13.2. Address: .............................................................................................................................

       Day & Time: ............................................................................................................................

       Tel. No.: ......................... Fax No.: .........................

   13.3. Address: .............................................................................................................................

       Day/Time: .................................................................................................................................

       Tel. No.: ......................... Fax No.: .........................

Date: .................................................................................................................................

Signature of applicant

* Delete whichever is inapplicable