FORM F

COUNCIL FOR PROFESSIONS SUPPLEMENTARY TO MEDICINE

REQUEST FOR GOOD STANDING LETTER

NAME: ……..……

HOME ADDRESS: ……..……

DATE OF REGISTRATION: ……..……...

REGISTRATION NO: ……..…….

PLACE OF EMPLOYMENT: ……..…….

PLACE OF EMPLOYMENT UP TO THE LAST FIVE (5) YEARS (give period)

……..……...……..

……..……..……...…….

NAME & TITLE OF PERSON TO WHOM LETTER IS TO BE ADDRESSED:

……..……...…...……..…

NAME & ADDRESS OF OVERSEAS REGULATORY BODY: ……..…..…..…

……..…..…...

……..

…….

SIGNATURE: ……

DATE: …….

NB. All fees are non-refundable