



Continuing professional development and recertification

Meeting record

Name *(Doctor registered within a general scope)* _____ MCNZ Reg No _____

Name *(Colleague)* _____ MCNZ Reg No _____

Meeting date _____ Duration _____

Type *(eg, face to face, telephone)* _____

Educational and quality assurance activities carried out since the last meeting

Commendations

Concerns and recommendations

Signed _____ Date _____

Signed _____ Date _____