



NZREX Clinical Application

- Exemption from English testing

NZREX5 – Feb 2006
For office use only
Candidate No:

PLEASE READ THE FOLLOWING, IT CONTAINS IMPORTANT INFORMATION.

- Council's policy on exemption from an approved English test is detailed at www.mcnz.org.nz
- All sections of this form are to be completed and the fee of NZ\$ 125.00 (GST inclusive) attached.
- Incomplete applications will not be processed.

SECTION 1 – Personal Identification details

(i) Name - Show given names from your passport or birth certificate, unless your name has been legally changed (e.g., by deed poll)

Family name _____
Given names _____

(iii) Contact details – Please print clearly.

Contact address _____ Phone (home) _____
 _____ Phone (work) _____
 _____ Mobile _____
 Email address _____ Fax _____

SECTION 2 – Exemption from English testing

(i) Have you read the Council's policy on exemption from an approved English test?

Yes No

(ii) Have you worked as a registered medical practitioner in an institution where English was the first and prime language for a period of at least two years, and within five years immediately prior to this application for exemption?

Yes (please provide details below and attach evidence) No

Dates (from – to)	Level of appointment	Branch of Medicine	Employer	Country

(iii) Please provide the names of at least two referees who are senior suitable medical practitioners who speak English as a first language, and can attest to your ability to communicate effectively in English in a clinical setting with both patients and professional colleagues. Referees will be contacted directly by the Council.

Name (in full)	_____		
Title	_____		
Employer	_____		
Contact address	Phone	_____	
	Fax	_____	
	Other (mobile)	_____	
Email address	_____		

Name (in full)	_____		
Title	_____		
Employer	_____		
Contact address	Phone	_____	
	Fax	_____	
	Other (mobile)	_____	
Email address	_____		

Name (in full)	_____		
Title	_____		
Employer	_____		
Contact address	Phone	_____	
	Fax	_____	
	Other (mobile)	_____	
Email address	_____		

SECTION 3 - Declaration

I understand that the information I have provided is used by the Medical Council for the purposes of considering my application and may be disclosed to the agents of the Medical Council for these purposes. I certify that the information I have provided is true and correct.

Applicant's signature _____ Date _____

SECTION 4 - Fees

Fee payable NZ\$125.00 Please indicate your payment option by ticking the appropriate box.

Cheque enclosed

Credit card option

Visa

Mastercard

Card number

Expiry date /

Name on card _____

Cardholder's signature _____ Date _____