Request for certificate of registration (Only required if you do not wish to request a Certificate of Professional Status)

COR
Jun 2019

SCAN and EMAIL to verification@mcnz.org.nz
or
Post to PO Box 10509, The Terrace, Wellington, 6143, New Zealand

Personal details:		
Medical Council registration number		
Name:	Former names:	
Date of birth:	Gender:	
Address for register - NZ or overseas. Registered address is public information:		
	Postcode:	
Confirm email		
Send certificate to:		
Name of organisation:		
Email address:		
Payment: A non-refundable application fee applies.		
For a current list of Medical Council fees please visit our website.		
☐ Credit card: Once your application has been received payment details will be emailed to the email address you have provided.		
☐ Cheque enclosed (payable to: Medical Council of New Zealand. Please put your registration number on the back).		
I consent to the above information being supplied.		
Doctors signature		Date