



**FORM D**

**PROFESSIONS SUPPLEMENTARY TO MEDICINE ACT, 1965**

**APPLICATION FOR THE RENEWAL OF PRACTICE LICENCES**

**ALL PROFESSIONS**

1. NAME IN FULL .....
2. MAIDEN NAME .....
3. RE-REGISTRATION AS: \_\_\_\_\_  
(NAME OF PROFESSION)
4. REGISTRATION NUMBER..... REGISTRATION DATE.....
5. CURRENT HOME ADDRESS: .....  
.....
6. CONTACT NO's.: .....
7. E-MAIL ADDRESS: .....
8. CURRENT PLACE OF PRACTICE: .....
9. PRACTICE ADDRESS: .....
10. TEL NO's: .....
11. LAST PLACE OF PRACTICE: .....
12. CONTINUING EDUCATION (CE) CREDITS:
  - ISSUED BY: .....
  - CREDIT HOURS: .....
13. I WISH TO HAVE MY NAME RETAINED IN THE REGISTER OF THE COUNCIL FOR THE PROFESSIONS SUPPLEMENTARY TO MEDICINE FOR THE YEAR.....  
AS A ..... THE FEE OF \$..... IS ENCLOSED.

SIGNATURE .....

DATE .....

The Completed Form is to be returned to:

**The Registrar,  
Council for Professions Supplementary to Medicine  
2-4 King Street, Kingston Jamaica W.I**

**\*To be certified by National Association**