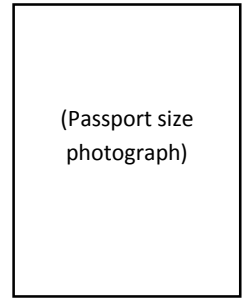


**APPLICATION FOR TEMPORARY PRACTISING  
CERTIFICATE OF A DENTAL SURGEON**



- 1. Full Name: .....
- 2. Passport No: ..... 3. Date of Expiry: .....
- 4. Citizenship: .....
- 5. Date of Birth: .....

- 6.
  - (a) Permanent Address:  
.....  
.....

- (b) Local Address:  
.....  
.....

Tel. No: ..... E-mail address: .....

7. Details of Basic Dental Qualification:

- (a) Degree Awarded (in full):  
.....
- (b) Name of Institution conferring degree:  
.....
- (c) Date awarded: .....

8. Details of Postgraduate Qualifications (if any):

- I. (a) Qualification Awarded (in full):  
.....
- (b) Name of Institution conferring degree:  
.....
- (c) Date awarded: .....

II. (a) Qualification Awarded (in full):

.....

(b) Name of Institution conferring degree:

.....

(c) Date awarded: .....

III. (a) Qualification Awarded (in full):

.....

(b) Name of Institution conferring degree:

.....

(c) Date awarded: .....

9. Professional Designation in country of origin:

.....

10. Duration of TPC: From ..... to .....

11. Principal Practising Address:

(a) Name of premises: .....

.....

Address: .....

.....

Telephone No.: .....

.....  
Signature of Dean/ Director

Other Practising Addresses:

(b) Name of premises: .....

.....

Address: .....

.....

Telephone No.: .....

.....  
Signature of Dean/ Director

12. Particulars of Bank draft/ Money order/ Postal order which is attached:

- (a) No.: ..... (b) Amount (RM): .....  
(c) Bank/ Post officer and date: .....

13. I attach the following documents as proof of my qualifications and in support of my application:

- (a) Certified copy of basic Dental Degree
- (b) Certified copy of Certificate of Registration as a dental surgeon from country of origin
- (c) Certified copy of passport
- (d) Two (2) recent passport size photographs
- (e) Letter of Good Standing from Dental Regulatory Body in country of origin
- (f) Certified copy of post-graduate qualification(s)
- (g) Certified copy of post-graduate academic transcript(s)
- (h) Evidence of clinical working experience
- (i) Payment of RM100
- (j) Letter or Offer of Employment from local sponsor
- (k) \* Evidence of experience as a specialist
- (l) \* Letter of Undertaking from university/ healthcare facility covering any and all emergencies
- (m) \* Letter of approval from university
- (n) \* Details of the procedure & course for transfer of skills and knowledge
- (o) \* Memorandum of agreement

Note: \* Denotes optional documents

## DECLARATION

I (full name) .....,  
hereby declare that the particulars stated in this application are true and correct, and the documents attached are true copies of original documents which relate to me.

I have not at any time been found guilty of an offence involving fraud, dishonesty or moral turpitude or any offence punishable with imprisonment (whether in itself or in addition to or in lieu of a fine).

Signature of Applicant: .....

Date: .....

---

**To be completed by the employer**

(√ where applicable)

14. Application for:

|   |  |
|---|--|
| A. Contract or exchange dental practitioner in the public sector  |  |
| B. Contract dental practitioner in Institutions of Higher Education   |  |
| a. as a dental lecturer   |  |
| b. as a dental practitioner   |  |
| C. External examiner invited by an Institution of Higher Education  |  |
| D. Dental practitioner who is visiting Malaysia to attend a short clinical hands-on course  |  |
| E. Dental specialist employed in a private hospital   |  |
| F. Dental expert engaged in transfer of skills and knowledge  |  |
| G. Contract and collaborating dental practitioner in the public sector or an Institution of Higher Education to conduct dental clinical research  |  |
| H. Dental practitioner undertaking voluntary community service  |  |
| I. Foreign post-graduate dental student in a dental faculty of a Malaysian Institution of Higher Education or in a Foreign Institution of Higher Education with a branch campus in Malaysia |  |

15. Details of university/ healthcare facility where clinical procedures will be carried out:

- (a) Name of university/ healthcare facility: .....
- (b) Address of university/ healthcare facility: .....  
.....
- (c) Tel. No.: .....

Signature of Dean / Director: .....

Date: .....

Name of Dean/ Director: .....