UGANDA MEDICAL AND DENTAL PRACTITIONERS COUNCIL
MINISTRY OF HEALTH
P.O. Box 16115, Kampala
Block 5. Plot 442 Kafeero Zone road
Off Mawanda road, Mulago Hill
Tel: +256-200-904427
E-mail: registrar@umdpc.com
Website: www.umdpc.com

APPLICATION TO CONDUCT SURGICAL/MEDICAL/DENTAL CAMP(S)

SECTION 1: DETAILS OF THE APPLICANT

a) Individual Application

Name (as it appears on the National ID/Passport):

_____

ID Number/Passport No.:_____ Nationality: _____

P.O. Box_____ _____Town _____District_____

Email address_____

Telephone No.: _____ Mobile No.:_____

b) Institutional Application

Name of the institution (as it appears on registration certificate/certificate of incorporation) where appropriate

_.....

.....

Country of Registration, where appropriate_____

P.O. Box_____ _____Town _____District_____

Physical Location:

_____

Email address_____

Telephone No.: _____ Mobile No.:_____

SECTION 2: DETAILS OF THE CAMP

Name of Camp Coordinator: _____

UMDPC Registration Number: _____

ID Number/Passport No.:_____ Nationality: _____

Duration of the surgical/medical/dental camp: _____

From: _____ To: _____

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Location:

District_____ Sub-District_____

Further details of the surgical/medical/dental camp site (include details of the specific location):

_____

_____

_____

Name of sponsoring entity_____

Country of registration of sponsoring entity, where appropriate_____

Estimated no. of patients to be seen_____

Services to be offered during the camp:

(i) _____

(ii) _____

(iii) _____

(iv) _____

(v) _____

SECTION 3: REQUIREMENTS

Attach the following documents, to this application form, in the prescribed order:

1. Copies of up-to-date licenses of **ALL** medical/dental practitioners involved in the surgical/medical/dental camp;
2. Copies of up-to-date licenses of **ALL** other health personnel involved in the surgical/medical/dental camp;
3. List of **ALL** medical/dental personnel involved in the surgical/medical/dental camp;
4. A copy of the registration certificate of the applying Institution
5. Letter of authorization from the District Health Office.
6. List of **ALL** Surgical/medical/dental Equipment/infrastructure and drugs (Note that any drugs brought from outside the country will need NDA approval);
7. Referral mechanism;
8. Waste management and disposal arrangements

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SECTION 4: LIST OF PRACTITIONERS

NO.	NAME	QUALIFICATION	REGISTRATION NUMBER
1.			
2.			
3.			
4.			
5.			

SECTION 5: DECLARATION

I solemnly and sincerely declare that the information given above is true to the best of my knowledge and belief.

Name and Signature of Camp Coordinator: _____

Date: _____

FOR OFFICIAL USE:

Decision taken:

_____
_____
_____
_____

Reason:

_____
_____
_____
_____
_____

The process will take a maximum of **two (2) weeks**.