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.go.ug
Website: www.umdpc.go.ug

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**.