MEDICAL AND DENTAL COUNCIL OF NIGERIA

A Parastatal of the Federal Ministry of Health. Established by Cap M8, Laws of the Federation 2004.

CABLES & TELEGRAMS MEDCOUNCIL ABUJA

HEAD OFFICE: F Close, 1st Avenue, Block II, Gwarinpa F.H.A. Estate. P.M.B 458, Garki,

:09-2902900, 2901435, 2901349, e-mail:info@mdcn.org, www.mdcn.org

FORM F
(Doctor's Copy)

PASSPORT

HOUSE OFFICERS' (INTERNSHIP) PERFORMANCE REPORT

Note Well: All entries in this form, except signatures, must be type-written, or written in capital letters.

* The Completed form must be returned directly to the Registrar of Council by the Hospital Administration IMMEDIATELY after the intern is signed.

(TO BE COMPLETED BY THE HOUSE OFFICER)

A **HOUSE OFFICER'S PARTICULARS**

(a) Full Names: _____
Surname First Name Middle Name

(b) Permanent Home Address: _____

(c) E-mail/Phone Number: _____

(d) Medical School/University Attended: _____

(e) Period of Attendance: _____

(f) Qualification Obtained (with date): _____

(g) Medical and Dental Council Registration Number: _____

(h) Date of Provisional Registration: _____

(i) Name of Training Hospital: _____

(TO BE COMPLETED BY SUPERVISING CONSULTANT)

B.

(a) Department of Posting: _____

(b) Period of House Officer's Posting in the Department

From: _____ _____ _____
Day Month Year

To: _____ _____ _____
Day Month Year

C. PERFORMANCE EVALUATION BY THE SUPERVISING CONSULTANT

(a) Rating Scale

A	=	Excellent	(80% and above)
B	=	Very Good	(70 – 79%)
C	=	Good	(60 – 69%)
D	=	Average	(50 – 59%)
E	=	Below Average	(40 – 49%)
F	=	Unsatisfactory	(Below 40%)

(b) **PARAMETERS**

	A	B	C	D	E	F
1. Knowledge and Application of Basic Medical Science						
2. Knowledge and Application of Clinical Science						
3. Knowledge of Pathological Basis of Medical Practice						
4. Level of Clinical Competence						
i. Medical Records - History Taking						
- Admission Work						
- Progress Notes						
- Case Summaries						
ii. Diagnostic Acumen						
iii knowledge and Application of Therapeutics						
iv Interaction with other members of the health team						
v. Compliance with Professional Ethics						
5. Motivation and Trainability						
i. Appropriate response to criticism						
ii. Ability to use the Library						
iii. Ability to present cases during rounds						
iv. Ability to learn and apply clinical skills						
v. Appropriate use of diagnostic facilities						
(a) Side Laboratories						
(b) Laboratory Requests						
(c) Radiological Requests						
(d) Follow -up of results						
6. General Behaviour: (a) Punctuality						
(b) Availability						
(c) Endurance						
(d) Personal Comportment						
(e) Neatness and Appropriate Attire						
(f) Sense of Responsibility						
(g) Inter Personal Relationship						
(h) Relationship with Hospital Authorities						
OVERALL EVALUATION SCORE:						

D: General Comments (including what you think he/she has acquired in the course of his/her internship with you)

_____

_____

_____

_____

E. Do you consider him/her a fit and proper person to be entered on the full Register of the Medical and Dental Council of Nigeria?

Yes ☐ **No** ☐

If No, give reasons and make further recommendations.

_____

_____

_____

F: PARTICULARS OF SUPERVISING CONSULTANT

(a) Full Names: _____ _____ _____
Surname First Name Middle Name

(b) Qualifications with dates: _____

_____

_____

(c) Medical & Dental Council Full Registration Number(s) with date:

_____

_____

(d) Medical & Dental Council Additional Qualification(s) Registration Number(s) with date(s):

_____

_____

(e) Rank in the Department/Hospital: _____

_____

_____
SIGNATURE AND DATE

_____
FULL NAMES OF THE HEAD OF DEPARTMENT

_____
SIGNATURE AND DATE

Note : 1. An Intern who has an average score of less than 60% (i.e C) may need to repeat the internship in the department concerned.

2. Supervising Consultants, heads of Department and Chief Medical Directors of Internship Training Hospitals are reminded that it is a professional misconduct for one to append his/her signature on a form which contains false or misleading information. Consultants shall be held responsible for the Veracity of assessments which they give on their names.

3. It is illegal for any medical graduate to commence internship posting without having been provisionally registered by the Council. It follows that any posting done before registration is invalid.

MEDICAL AND DENTAL COUNCIL OF NIGERIA

A Parastatal of the Federal Ministry of Health. Established by Cap M8, Laws of the Federation 2004.

CABLES & TELEGRAMS MEDCOUNCIL ABUJA

HEAD OFFICE: F Close, 1st Avenue, Block II, Gwarinpa F.H.A. Estate. P.M.B 458, Garki, Abuja. F.C.T

:09-2902900, 2901435, 2901349, e-mail:info@mdcn.org, www.mdcn.org

FORM E
(Doctor's Copy)

CERTIFICATE OF PRE-REGISTRATION EXPERIENCE

TO BE COMPLETED BY THE DESIGNATED OFFICIAL OF THE HOSPITAL

It is hereby certified that DR _____

Surname *First Name* *Middle name*

Of _____

Address

Who qualified with the _____ Degree (s)

Qualification

Of the _____

Name of Institution

Was employed as an intern in a resident Medical/Dental capacity as defined in section 17 of the Medical and Dental Practitioners' Act 1990, Cap 221, Laws of the Federal Republic of Nigeria, in the under-mentioned approved Hospital or Institution for the period specified hereunder, and his/her services while so employed was found SATISFACTORY/ UNSATISFACTORY (delete which is not appropriate) as per attached certificate of performance (Form F).

Name of Hospital: _____

Period of Employment From: _____

Day *Month* *Year*

To: _____

Day *Month* *Year*

Full Names of head of the Institution: _____

Qualification: _____

Full Registration Number: _____

Stamp

Additional Qualifications(s) Registration Number (s) Date (s): _____

_____

E-mail & Phone No. _____

State/L.G.A. _____

Signature: _____ Date: _____

Note: **The Signature below should be that of the Chief Medical Director/ Medical Director or Chairman Medical Advisory committee / Director of General Services or other officers of the employing Body authorized to act in his behalf.**

Stamp

Signature: _____

Name: _____

Official Position: _____ **Date:** _____