SLMC Provisional Registration No: .....

FORM A

INFORMATION SHEET
TO BE POSTED TO THE SRI LANKA MEDICAL COUNCIL
ON REPORTING FOR INTERNSHIP

FULL NAME OF INTERN : .....

.....

NAME WITH INITIALS: .....

HOME ADDRESS : .....

.....

E-MAIL ADDRESS : ..... MOBILE NO : .....

NATIONAL IDENTITY CARD NO :..... SEX : .....

DEGREE AND UNIVERSITY : .....

..... YEAR OF GRADUATION: .....

COMMON MERIT LIST NO : ..... MONTH / YEAR : .....

DATE OF COMMENCEMENT OF INTERNSHIP : .....

ALLOCATION OF APPOINTMENTS

1) SPECIALITY : ORAL & MAXILLOFACIAL SURGERY (6 Months)

   NAME OF CONSULTANT : ..... PERIOD : .....

2) SPECIALITY : RESTORATIVE DENTISTRY (3 MONTHS)

   NAME OF CONSULTANT : ..... PERIOD : .....

3) SPECIALITY : ORTHODONTICS (3 MONTHS)

   NAME OF CONSULTANT : ..... PERIOD : .....

.....

1). SIGNATURE OF THE DIRECTOR / MS/DMO OF THE HOSPITAL

.....

SIGNATURE OF INTERN

DATE : .....

.....

2). SIGNATURE OF THE DIRECTOR / MS/DMO OF THE HOSPITAL

.....

3). SIGNATURE OF THE DIRECTOR / MS/DMO OF THE HOSPITAL