MEDICAL AND DENTAL COUNCIL OF NIGERIA

CPD ACTIVITY RECORD FOR YEAR……

1. NAME OF DOCTOR……
   SURNAME FIRST NAME MIDDLE NAME
2. FOLIO NUMBER……BUSINESS ADDRESS……
3. EMAIL……TEL NO……
4. QUALIFICATIONS(with dates, institution, MDCN Reg.No)

   (a) Basic: …… Additional: ……

Date of CPD	Type of CPD	No of CPD Units	Name of Provider	Signature of CPD Provider Representative

Total Number of CPD units acquired……

I certify that the information above is correct to the best of my knowledge bearing in mind that any wrong information entered may result in my being sanctioned.

…….

Signature of Doctor/Date