

**APPLICATION FORM FOR THE GRANTING OF THE LICENCE BY THE PRESIDENT
COUNCIL FOR THE PROFESSIONS COMPLEMENTARY TO MEDICINE – MALTA**

(LN 277 of 2008 – Professions Complementary to Medicine (Licence to Practise) Regulations 2008)

Name & Surname
(Give full name in capital letters, surname underline)

Date of birth Nationality
(day, month, year)

I.D. No./Passport No.

Permanent Address

.....
.....

Tel. No. and/or Mobile No. E-mail

Registered in the

(indicate under which Register you are registered with the CPCPM)

Signature of applicant

Date of application

The applicant authorizes the Council to make use of the data in accordance to the Data Protection Act (Cap. 440).