WEST SHORE MEDICAL LIMITED
#239 Western Main Road, Cocorite, Trinidad & Tobago
Phone: (868) 622-9878 or 285-5019 Fax: (868) 622-3289
E-mail: wsm@westshorett.com
www.westshoreprivatehospital.com

DOCTOR'S PRACTISING PRIVILEGES

DOCTOR'S NAME: DATE OF BIRTH:

ADDRESS:

PHONE #: FAX #: CELL #:

EMAIL:

DATE OF APPLICATION:

MEDICAL SCHOOL:

DEGREES & YEARS QUALIFIED:

EXPERIENCE:

SPECIALTY:

REGISTRATION WITH MEDICAL BOARD OF TRINIDAD AND TOBAGO

REG. NO.: DATE RENEWED:
EXPIRY DATE:

MALPRACTICE INDEMNITY INSURANCE

Name of Organization:

Reg. No: Expiry Date:

NB: - Please enclose copies of all registrations

I will/will not be available to cover emergencies.

I hereby certify that all information given on this form to be true to the best of my knowledge.

_____
SIGNATURE