SLMC Provincial 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:……..

……

EMAIL:…… MOBILE NO:……...

NATIONAL IDENTITY CARD NO:…… SEX:……..

DEGREE AND UNIVERSITY: …… YEAR:……..

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

DATE OF COMMENCEMENT OF INTERNSHIP:……

HOSPITAL ALLOCATED FOR INTERNSHIP:……..

ALLOCATION OF APPOINTMENTS:

1ST SIX MONTHS: SPECIALITY:……

PERIOD:……

2ND SIX MONTHS: SPECIALITY:……..

PERIOD:…….

NAME/S OF CONSULTANTS:

1ST SIX MONTHS: NAME:……

2ND SIX MONTHS: NAME: ……

…….. ……

SIGNATURE OF INITERN

SIGNATURE OF THE DIRECTOR/MS/DMO
OF THE HOSPITAL

DATE: ……