Overseas Registration: Health Verification

International Registrations, 23 Portland Place, London, W1B 1PZ Phone: +44 20 7333 6600 Web: www.nmc.org.uk

Nursing & Midwifery Council

To the applicant: This section must be completed by the occupational health department where you are currently employed or by a registered medical practitioner. The declaration must be no more than three months old at the time the application for registration is submitted to the NMC. If the declaration is expired we will ask you to provide a current declaration.

To the REGISTERED MEDICAL PRACTITIONER/OCCUPATIONAL HEALTH DEPARTMENT representative:
The applicant named below has recently submitted an application to register with us. They've told us that you will be able to verify the information they've provided to us. So they can continue their application, we need you to confirm that the information they provided is correct and matches your records.
They have confirmed that you have been informed that we will contact you and have given us their consent to do so.
We need to know that people applying to join the register meet our health requirements to ensure they can practise safely and effectively.

Please enter your details below and complete the questions that follow. You must be an occupational health department representative or a registered medical practitioner.
Please complete all sections and provide any further details which you may consider relevant on a separate sheet. The NMC may make further enquiries of the applicant or yourself in order to verify or clarify any part of this reference.

Applicant's details

Name of applicant	ANISHA TONY
PRN	1021434015
Date of birth (DD/MM/YYYY)	02 09 1996

Registered Medical Practitioner's / OH Practitioner's details

Your name	DR.JACOB GEORGE
NMC PIN (if applicable)	
Job title	REGISTERED MEDICAL PRACTITIONER
Organisation name	MOUNT ZION MEDICAL COLLEGE
Address Line 1	CHAYALODE P.O
Address Line 2	
Town/City	ADOOR
Postcode/Zip code	691556
Country	INDIA
Email address	jacobgeorgejg1997@gmail.com
Telephone number	+91 8593057966

Health Verification (continued)

Is your profession regulated? Yes [✓] No [ ]

Your regulator name: DR.JACOB GEORGE

Your registration number: _____

As part of their application the applicant has told us that: they have no health condition or disability that could affect their practice.

Do you declare, based on your current knowledge and assessment of the applicant, that you agree with the information they have provided about their health?

Yes [✓] No [ ]

If you have answered No above please provide your reason(s)

Health condition(s) and/or disability

If the applicant has declared that they have a health condition and/or disability OR you have told us that they do, please complete this section.

Based on your health assessment do you feel the health condition and/or disability is being managed appropriately to enable safe and effective practice?

Yes [ ] No [ ]

If you wish to provide any further supporting information you may enter it here or attach another document together with this form when you email it to us.

I declare that the information I have provided is true and accurate to the best of my knowledge.

Date (DD/MM/YYYY) 1 0 | 0 2 | 2 0 2 2

Signature