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|  | <p style="text-align: center;">BOARD OF GOVERNORS IN SUPERSESSION OF MEDICAL COUNCIL OF INDIA Pocket - 14, Sector - 8, Phase-I, Dwarka, New Delhi - 110 077 Phone : 011-25367033,25367035, 25367036, Email : mci@bol.net.in, Website : http://www.mciindia.org</p> |
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ANNEXURE – I

PROFORMA FOR SUBMITTING APPEAL CASES UNDER SECTION 8.7 & 8.8 OF INDIAN MEDICAL COUNCIL (PROFESSIONAL CONDUCT, ETIQUETTE AND ETHICS) REGULATIONS, 2002.

FOR (Complainant before State Medical Council) APPELLANTS PREFERRING APPEAL AGAINST THE DECISION OF STATE MEDICAL COUNCIL

1. Name of the appellant: _____
(In Block letters)

2. Full Postal address of the appellant _____
City _____ District _____ State _____
Pin Code _____
Telephone No. _____ (O) _____
® _____ Mobile _____
E-mail _____

3. Bank Draft No. _____ dated _____ for Rs. _____

Drawn on (Name & address of issuing branch) _____

4. Does the appellant belong to BPL category: Yes/No
If yes, proof may be submitted and listed below _____

5. If the appellant is same person who has lodged the original complaint:

6. The name and addresses alongwith particulars of the doctor(s) against whom complaint is lodged.
Name of the doctor: _____
Registration number: _____
(Name of the State Medical Council) _____
Address: Residential _____

Clinic/Hospital: _____
_____ Pin code: _____

Office: _____
Telephone No. _____ Pin code: _____
E-mail ID _____

(Additional Sheets are to be used in case there is more than one doctor is involved.)

7. Nature of the appeal in brief -

- 1.
- 2.
- 3.
- 4.

8. Has the State Medical Council not passed order on the complaint within stipulated time period of 6 months?

Yes/No

9. Name of the State Medical Council against whose decision the appeal is lodged (enclose a copy of the decision of the State Medical Council with all the relevant papers).

Reasons for not being satisfied of ruling of State Medical Council

- 1.
- 2.
- 3.
- 4.
- 5.

I hereby affirm and declare that the information provided above are true to the best of my knowledge and belief and nothing has been concealed therein.

Date:

Signature _____

Place:

Name in full: _____

INSTRUCTIONS FOR APPEAL

1. The Application Form should be properly and neatly filled in.
2. Incomplete applications shall not be entertained by the Council.
3. A Bank draft of Rs. (500/-+18% GST) in favour of “The Secretary, Medical Council of India”, payable at New Delhi should be sent alongwith the application as fee (cheques are not acceptable). On reverse of draft, following details will be filed by the applicant and duly signed: -
 - (a) Name:
 - (b) Father’s Name:
 - (c) Purpose:
 - (d) Contact Telephone/Mobile No.:
4. Persons Below Poverty Line (BPL) shall not have to pay any fees for the original complaints or the appeals as the case may be provided that a certificate issued by a government Authority/attested copy of the BPL Card issued by the Competent Authority is attached with the complaint/appeal.
5. Applicant to retain copy of Appeal and bank draft for future reference.
6. Applicant to attach the affidavit with the complaint as per given proforma on Rs.50/- stamp paper duly attested by Notary Public.



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ACKNOWLEDGEMENT

(to be filled by the candidate)

Received Application from Ms/ Mr.
D/o / S/o Sh. alongwith Bank Draft/
DD No. Dated for Rs.....
drawn on Bank
for lodging Appeal.

OFFICIAL
SEAL

Signature of Receiving Official
with date

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ANNEXURE – II

PROFORMA FOR SUBMITTING APPEAL CASES UNDER SECTION 8.7 & 8.8 OF INDIAN MEDICAL COUNCIL (PROFESSIONAL CONDUCT, ETIQUETTE AND ETHICS) REGULATIONS, 2002

FOR REGISTERED MEDICAL PRACTITIONERS PREFERRING APPEAL AGAINST THE DECISION OF STATE MEDICAL COUNCIL.

1. Name of the appellant/Doctor: _____
(In Block letters)

2. Registration number: _____
(Name of the State Medical Council) _____

3. Full Postal address of the appellant _____
Address: Residential _____

Clinic/Hospital: _____ Pin code: _____

Office: _____
Telephone No. _____ Pin code: _____
Mobile _____
E-mail _____

4. Bank Draft No. _____ dated _____ for Rs. _____

Drawn on (Name & address of issuing branch) _____

5. Nature of the appeal in brief -
 - 1.
 - 2.
 - 3.
 - 4.

6. Name of the State Medical Council against whose decision the appeal is lodged (enclose a copy of the decision of the State Medical Council with all the relevant papers).

Reasons for not being satisfied of ruling of State Medical Council

- 1.
- 2.
- 3.
- 4.
- 5.

I hereby affirm and declare that the information provided above are true to the best of my knowledge and belief and nothing has been concealed therein.

Date:

Signature_____

Place:

Name in full:_____

INSTRUCTIONS FOR APPEAL

1. The Application Form should be properly and neatly filled in.
2. Incomplete applications shall not be entertained by the Council.
3. A Bank draft of Rs. (500/-+18% GST) in favour of “The Secretary, Medical Council of India”, payable at New Delhi should be sent alongwith the application as fee (cheques are not acceptable). On reverse of draft, following details will be filed by the applicant and duly signed: -
 - (a) Name:
 - (b) Father’s Name:
 - (c) Purpose:
 - (d) Contact Telephone/Mobile No.:
4. Persons Below Poverty Line (BPL) shall not have to pay any fees for the original complaints or the appeals as the case may be provided that a certificate issued by a government Authority/attested copy of the BPL Card issued by the Competent Authority is attached with the complaint/appeal.
5. Applicant to retain copy of Complaint/Appeal and bank draft for future reference.
6. Applicant to attach the affidavit with the complaint as per given proforma on Rs.50/- stamp paper duly attested by Notary Public.



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ACKNOWLEDGEMENT

(to be filled by the candidate)

Received Application from Ms/ Mr.
D/o / S/o Sh. alongwith Bank Draft/
DD No. Dated for Rs.....
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OFFICIAL
SEAL

Signature of Receiving Official
with date