



**ACADEMY OF FAMILY PHYSICIANS OF MALAYSIA
ATFM MENTOR APPLICATION FORM**

	Clinical
	Research

Full name:			
New IC Number:		Years in General Practice :	
Telephone:	H:	Select Your Qualification as Appropriate:	Year Obtained
	HP:	<input type="checkbox"/> MAFP	
AFPM Membership Number & Member since (date):		<input type="checkbox"/> FRACGP/icFRACGP	
NSR Registration Number:		<input type="checkbox"/> MCGP	
E-mail Address:		<input type="checkbox"/> M.Med (Family Medicine)	
Correspondence Address:		<input type="checkbox"/> Others: MRCGP/ MINTFM/ PHD	
Current place of employment (full add and tel. no); & Present Appointment (General Practice, other relevant post):			
Postgraduate Experience:			
Teaching /Research Experience:			
Special Interest (Research):			
State the name and full contact detail of your two (2) Referees			
Name of Referee 1:		Name of Referee 2:	
Address:		Address:	
Number:		Number:	
Email Address:		Email Address:	
Your Signature & Official Stamp :		Date :	
		Approval from COT/MPCRG:	

Note: Please attach a copy of your updated Curriculum Vitae with this form.