



MALTA COLLEGE OF FAMILY DOCTORS
127, Professional Centre,
Sliema Road, Gzira, GZR 1633 MALTA (Europe)
Email: contact@mcfd.org.mt
Website: <http://www.mcfd.org.mt>

Call for President of MCFD Council 2025

Dear Colleague,

President-Elect Dr Leonard Callus submitted his resignation on 4th April 2025.

Subsequently, the MCFD Statute describes to proceed to election of President of the MCFD.

The Electoral Commission has been informed of the need to fill this vacancy.

Interested candidates are to send an application form with the due signatures of nominee and proponents to the Electoral Commission on the address given below.

The Nominee and the Proponents must be:

1. a Specialist in Family Medicine
2. a **full member** of the Malta College of Family Doctors
3. a **fully paid up member** of the Malta College of Family Doctors
4. in good standing with the Medical Council
5. in good standing with the Malta College of Family Doctors.

Documentation to prove the above is to be attached with the application form.

Applications will be received till 20th April 2025 to the attention of the:

MCFD Electoral Commission c/o Dr Jurgen Abela, 16-18 Triq Mons.Debono, Luqa LQA 1791.

Dr Edward Zammit
Honorary President MCFD

Dr Jason Bonnici
Honorary Secretary MCFD

5th April 2025



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Application form for President

I, the undersigned _____ accept the nomination to run for
President of the Malta College of Family Doctors.

I am a Specialist in Family Medicine, I am a full member of the Malta College of Family Doctors, I am a fully paid up member of the Malta College of Family Doctors, I am in good standing with the Medical Council and I am in good standing with the Malta College of Family Doctors.

The necessary documentation is attached with this application.

I will abide with the rules and regulations of the MCFD Electoral Commission.

Signature of **Nominee**: _____

Name and Surname: _____

College Number: _____

Medical Registration Number: _____

Signature of **Proponent 1**: _____

Name and Surname: _____

College Number: _____

Medical Registration Number: _____

Signature of **Proponent 2**: _____

Name and Surname: _____

College Number: _____

Medical Registration Number: _____