

Form 23 MT

NON COMPLIANT APPLICATION WILL BE REJECTED AND SENT BACK TO YOU!

Please PRINT and return the ORIGINAL FORM to:

The Registrar, PO Box 205, Pretoria 0001 **by registered mail for ease of tracking mail**
553 Madiba Street, Arcadia, Pretoria 0083

**FOR
OFFICE
USE ONLY**

A. PERSONAL PARTICULARS

HPCSA Registration Number: _____

I, (Dr, Mr, Mrs, Miss) _____ Surname: _____

Maiden name (if applicable): _____

First names: _____ Identity No.: _____

Postal address: _____ Postal code: _____

Residential address: _____ Postal code: _____

Tel (H): _____ (W): _____

Cell: _____ Fax: _____

Email: _____

* Marital Status: Divorced Married Single Gender: Male Female

* Race: Asian African Coloured White Country of origin: _____

Hereby apply to register as _____ and declare that I am the person referred to in the certificate below. I also declare that I have never been convicted of any criminal offence or been debarred from practice by reason of unprofessional conduct in any country and that, to the best of my knowledge and belief, no proceedings involving or likely to involve a charge of offence or misconduct is pending against me at present.

SIGNATURE: _____ **Date:** _____ **20** _____

Received on _____

Amount _____

Receipt No. _____

Reg. Date _____

I certify that the application meets the requirements as outlined in section B and that I have verified the application:

Registration Officer: _____

Signature: _____

Date: _____

B. THE FOLLOWING IS SUBMITTED IN SUPPORT OF MY APPLICATION:

- | | |
|--|------------------------------------------------------------------------------------------------------------|
| | 1. Registration fee, plus the pro rata annual fee obtainable from the HPCSA Call Centre at 012 338 9300. |
| | 2. A copy of my identity document or birth certificate. |
| | 3. A copy of a letter from SMLTSA confirming passing of Board examination. |
| | 4. A copy of my marriage certificate (should you wish to register in your married surname). |
| | 5. A copy of my registration certificate as a student with the Health Professions Council of South Africa. |

C. TO BE COMPLETED BY THE UNIVERSITY/UNIVERSITY OF TECHNOLOGY/COLLEGE

NB: ALTERATIONS TO THIS SECTION WILL NOT BE ACCEPTED

Name of University/University of Technology/College: _____

It is hereby certified that _____ complied with all the requirements for the Degree/Diploma/Certificate _____ of this institution on _____ (day) _____ (month) _____ (year) and that this qualification will be conferred/issued at a graduation ceremony on _____ (day) _____ (month) _____ (year).

WE RECOMMEND him/her for registration

ORIGINAL OFFICIAL DATE STAMP OF INSTITUTION

SIGNATURE: RECTOR/DEAN/OPERATIONAL HEAD _____ **DATE** _____

SIGNATURE: REGISTRAR/REGISTRAR _____ **DATE** _____