Health Professions Council of South Africa

Form 24 OS

APPLICATION FOR REGISTRATION

PROFESSIONAL BOARD FOR MEDICAL ORTHOTICS/PROSTHETICS

NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION

Please PRINT and return the ORIGINAL FORM to:
The Registrar, PO Box 205, Pretoria 0001
553 Madiba Street, Arcadia, Pretoria 0083

FOR OFFICE USE ONLY

Received on

Amount

Receipt No.

No.

Reg. date

VERIFIED

DATE

CAPTURED

DATE

VERIFIED

DATE

A. PERSONAL PARTICULARS

HPCSA Registration Number: .....

I, (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 for registration as a Medical Orthotics/Prosthetics in the category: .....
and hereby make oath and declare that I am the person mentioned.

SIGNATURE: ..... **Date:** ..... **20** .....

SWORN BEFORE ME AT: ..... this ..... day of ..... **20** .....

SIGNATURE: .....

COMMISSIONER OF OATHS/JUSTICE OF PEACE for the district of .....

B. The following is submitted in support of my application:

	1. My original diploma/degree (a copy will only be accepted if certified by an attorney in his/her capacity as **Notary Public** and bearing the official stamp, or Form 23, duly completed.) Copies certified by a Commissioner of Oaths **will not be accepted**.
	2. Current registration plus the pro rata annual fee obtainable from the HPCSA Call Centre at 012 338 9300.
	3. Form 27 OS duly completed.
	4. A copy of my identity document or birth certificate.
	5. A copy of my marriage certificate (should you wish to register in your married surname).
	6. A copy of my certificate as a student with the Health Professions Council of South Africa.

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

C. CERTIFICATE OF HEALTH

I, ... of (address) .....

..... a medical practitioner,

certify that I have medically examined ..... the applicant, and I declare that his/her health is such that it would not be detrimental to patients or to him-/herself to engage in the duties of his/her profession.

SIGNATURE: ..... **Date:** ..... **20** .....

D. CERTIFICATE OF CHARACTER

I, (full names): ..... of address .....

Working as .....

(Medical Practitioner, Minister of Religion, Magistrate or other responsible person) certify that

..... the applicant, is personally known to me and that he/she is of good character.

SIGNATURE: ..... **Date:** ..... **20** .....

*** Please complete for statistical purposes.**

NB: Please note that the Council, in the normal course of its duties, reserves the right to divulge information in your personal file to other parties.