

**APPLICATION FOR APPROVAL OF CONTINUING PROFESSIONAL  
DEVELOPMENT (CPD) ACTIVITIES**

**Please complete and submit this application to a Profession-specific Accreditor**  
**NOTE: The Programme for the Activity and the Presenter's CV must be submitted with this application preceding the activity. No retrospective approval will be made.**

Name of Providing Organisation/Provider (Including Registration Number)		
Postal Address of Providing Organisation/Provider		
Target Audience (eg. Medical Practitioners, Occupational Therapy)		
Contact Person (Providing Organisation/Provider)		
Telephone Number (Including Area Code) (Providing Organisation/Provider)		
Fax Number (Including Area Code) (Providing Organisation/Provider)		
e-Mail Address (Providing Organisation/Provider)		
Activity Title		
The potential of the activity to enhance professional performance (Required for reporting to HPCSA)		
Date(s) of Activity/Programme		
Venue (Full Address) of Activity (If Applicable)		
Level of Proposed CPD Activity		
Registration Fee involved for participants		
Duration of the learning activity (hours)		
Suggested CEU's (General)	Level 1	
Suggested CEU's in Medical Ethics, Human Rights and Legal Issues pertaining to health sciences	Level 1	
Suggested number of CEU's (Indicate Maximum CEUs in each Level)	Level 1	

<b>Specify intended method of evaluation (e.g. Questionnaire)</b>	
<b>Specify the intended mechanism for monitoring attendance (per hour or per session) for the duration of the activity</b>	
<b>Have you applied to another accreditor to have this activity approved? If yes, to whom and what was the outcome? Provide reason if the application was not approved.</b>	Name of Accrerator: No. Outcome and reason .....

**Organisations/Providers:**

With the submission of this application, I

- a. submit my advertisement
- b. declare that the activity would not be advertised without prior approval of the Accrerator
- c. undertake to monitor the attendance for the duration of the activity
- d. evaluate the presentations as specified and to inform the accreditors accordingly
- e. recognize the authority of the Board/Accreditors to cancel the accreditation in the event of non-compliance with the criteria.
- f. Declare that there is no conflict of interest

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Designation:** \_\_\_\_\_

**FOR THE OFFICIAL USE OF THE ACCRERATOR**

This is to certify that .....(name of Accrerator) -  
has agreed to the proposed CPD CEUs as follows:

Level 1	Ethics/Human Rights/Legal Matters

Specify ethical/human rights/health law relating to health sciences

TOTAL:

Specify the reasons why the learning activity has not been accredited:  
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**SIGNATURE ON BEHALF OF DESIGNATED CPD ACCRERATOR**

**DATE:** \_\_\_\_\_

<b>NAME AND DESIGNATION:</b>	
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