



Health Professions Council of South Africa

Form 23 DOH

PROFESSIONAL BOARD FOR DENTAL THERAPY AND ORAL HYGIENE APPLICATION FOR REGISTRATION

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 or 553 Madiba Street, Arcadia, Pretoria 0083 by registered mail or courier for ease of tracking mail.

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: Married Single Divorced Gender M F
\* Race: African Asian Coloured Indian White Country of Origin:

hereby apply to register as

Audiologist Speech Therapist Speech Therapist and Audiologist Hearing Aid Acoustician

I declare that I am the person referred to in the attached certificate or qualification referred to 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 in any country at present.

SIGNATURE: Date: 20

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

- 1. Registration fee R703 and prorata annual fee obtainable from 012 338 9300 and banking details click here. (Registration number as deposit reference) Please attach proof of payment.
2. A copy of my marriage certificate (should you wish to register in your married surname).
3. A copy of my identity document or birth certificate.
4. A copy of my registration certificate as a student with the Health Professions Council of South Africa.

ALTERATIONS TO THIS SECTION WILL NOT BE ACCEPTED

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

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).

I consider him/her to be a competent and fit person to practice as a

WE RECOMMEND him/her for registration ORIGINAL OFFICIAL DATE STAMP OF INSTITUTION
SIGNATURE: RECTOR/DEAN/OPERATIONAL HEAD DATE
SIGNATURE: REGISTRAR/PRINCIPAL DATE

\* 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.