



HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

**CERTIFICATE OF COMPLETION OF
COMMUNITY SERVICE**

**Form 27
Comm Service Completed**

NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION

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

DECLARATION

It is hereby certified that:

HPCSA Registration Number: _____

Dr/Mr/Mrs/Miss: _____

Was employed at this institution (name and address of training institution):

From: _____ To: _____

As a _____

Category (if applicable) _____

that he/she complied with the requirements of community service as determined by the Department of Health; and that his/her service was satisfactory.

1. _____
SIGNATURE: Head of the Department/Directorate **Name: Please print**

Designation: _____

Date: _____ 20 _____

Telephone number: _____

2. _____
SIGNATURE: Medical Superintendent/Head of Institution **Name: Please print**

Designation: _____

Date: _____ 20 _____

Telephone number: _____

OFFICIAL DATE STAMP OF INSTITUTION

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.