Health Professions Council of South Africa

Form 24 DA
LIMITED REGISTRATION

PROFESSIONAL BOARD FOR DENTAL THERAPY AND ORAL HYGIENE

APPLICATION FOR REGISTRATION AS A DENTAL ASSISTANT

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

DA

Received on .....

Amount .....

Receipt No. .....

No. .....

Reg. date .....

Bank Details:

HPCSA
Bank: **ABSA**
Branch: **Arcadia**
Branch code: **334945**
Acc. No. **0610000169**

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

Registration Officer: .....

Signature: .....

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 to register as ..... with limited registration and declare that I am the person referred to in the certificate below. I understand and acknowledge that I am applying for LIMITED REGISTRATION as a Dental Assistant, and that such registration will lapse after a period of two (2) years from the date of acceptance of this application by the HPCSA, with the understanding that no such application for registration shall occur after the expiry of four months from the date. I understand that in order to gain full registration as a Dental Assistant I would need to successfully complete a Board Examination within a period of two years, and that I will be afforded three (3) opportunities to undertake such examination. I further understand that if I do not successfully complete the Board Examination within the stipulated time period then I will be removed from the register and I will then have to obtain a qualification from a HPCSA recognised Higher Education Institution, and reapply for registration as a Dental Assistant.

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:

- ☐ A certified copy of my identity document
- ☐ A copy of my marriage certificate (should you wish to register in your marriege surname)
- ☐ Current registration fee of R 697.00 plus the pro rata annual fee obtainable from the HPCSA Call Centre at 012 338 9300. Please attach a copy of the proof of payment.

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

C.

I ……..(Name of Dental Specialist, Dentist, Dental Therapist and/or Oral Hygienist)
with identity number……and HPCSA registration number ……..
of (full business address and postal code)……..
…… Daytime contact telephone number (…..)……)
hereby certifies that ……(applicants full name) with identity number……
has experience as a dental assistant and has been supervised by me.
SIGNATURE: …… Date: ……2017
SWORN BEFORE ME AT: …… This…..... day of……2017
SIGNATURE:_____
COMMISSIONER OF OATHS/JUSTICE OF PEACE for the district of……
COMMISSIONER OF OATHS NAME, ADDRESS, OFFICIAL STAMP

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

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.