



Form 24 KT-G

PROFESSIONAL BOARD FOR RADIOGRAPHY AND CLINICAL TECHNOLOGY

APPLICATION FOR REGISTRATION CLINICAL TECHNOLOGIST

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

NO ALTERATIONS TO THIS DOCUMENT WILL BE ACCEPTED

FOR OFFICE USE ONLY

A. PERSONAL PARTICULARS

HPCSA Registration Number: I, (Mr, Mrs, Miss) Surname: Maiden name (if applicable): First names: Identity No.: Postal address: Residential address: Tel (H): Cell: Email: * Marital Status: Divorced Married Single Gender: Male Female * Race: Asian African Coloured White Country of origin:

Received on Amount Receipt No. No. Reg. date

hereby apply for registration as a Clinical Technologist in the category: and hereby make oath and declare that I am the person mentioned in the attached documents submitted by me in support of my application for registration and that all the said documents were granted to me and are my own lawful property.

I also declare that I have never been convicted of any criminal offence or been debarred from practice by reason of misdemeanor or 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 SWORN BEFORE ME AT: this day of 20 SIGNATURE: COMMISSIONER OF OATHS/JUSTICE OF PEACE for the district of

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

- B. The following is submitted in support of my application: 1. My original B-Tech degree... 2. Registration fee of R610.00... 3. A copy of my identity document... 4. A copy of my marriage certificate... 5. A copy of my certificate as a student...

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

Registration Officer: Signature: Date:

C. CERTIFICATE OF HEALTH

I, of (address) a registered 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.