Form 24 TT

PROFESSIONAL BOARD FOR DENTAL THERAPY AND ORAL HYGIENE

APPLICATION FOR REGISTRATION
AS A DENTAL THERAPIST

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

TT

Received on ....

Amount ....

Receipt No. ....

No. ....

Reg. 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 .... in the category ………………………… and declare that I am the person referred to in the certificate below. Further, I have never been convicted of any criminal offence or been debarred from practising my profession in any country by reason of a criminal offence or unprofessional conduct and 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 B and that I have verified the application:

Registration Officer:

…………………

Signature:

…………………

Date:

…………………

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

1. ☐ My original certificate (a copy will only be accepted if certified by an attorney in his/her capacity as **Notary Public** and bearing the official stamp, or Form 23, duly completed.) Copies certified by a Commissioner of Oaths **will not be accepted**.
2. ☐ Registration fee of **R670.00**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.
3. ☐ A copy of my identity document or birth certificate.
4. ☐ A copy of my marriage certificate (should you wish to register in your married surname).

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

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** ....

*** 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.

Updated/LS/04-2016