Health Professions Council of South Africa Form CPD 5	**ANNUAL REPORT: ACCREDITORS**

TRAINING INSTITUTION / ASSOCIATION NAME	
Providing organisation and/or Name of provider	
Name of CPD co-ordinator or administrative person	
Postal Address	
Contact Telephone	
Contact Fax No	
Cell No	
E-mail address	

ACCREDITED SERVICE PROVIDERS APPROVED	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	
Service Provider Details (Institution Name)	

ACCREDITED SERVICE PROVIDERS NOT APPROVED	
Institution Details	
Reason for not accrediting	
Institution Details	

Reason for not accrediting	
Institution Details	
Reason for not accrediting	
Institution Details	
Reason for not accrediting	
Institution Details	
Reason for not accrediting	

ACTIVITIES APPROVED BY ACCREDITORS									
Provider	**Accreditation No**	**Activity**	**Level**	**CEUs**	**Date of Activity**		**Ethics, Human Rights or Medical Law**		**Indicate the potential of the activity to enhance professional performance**
					Start	**Finish**	**CEUs**	**Topic**	

PROBLEMS/CHALLENGES EXPERIENCED

OTHER COMMENTS

DETAIL OF PERSON COMPLETING THE FORM	
Name and Surname	
Designation	
Date	
Signature	