Health Professions Council of South Africa

Form 24 DA

APPLICATION FOR REGISTRATION

AS A DENTAL ASSISTANT

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

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 make oath and declare that I am the person mentioned in the attached documents submitted by me in support of my application and declare that all the said documents were granted to me and are my own lawful property; and further that I have never been debarred from practicing in any country by reason of professional misconduct 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. (Full particulars of the reason for your inability to do so will be required if you are unable to make this declaration.)

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:

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

	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: **R902.00** Annual Fee: **R1001.00 applicable from the period 1 April 2024 to 31 March 2025**. Banking details as on the website **(Registration number as deposit reference) Please attach 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).

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.