



PROFESSIONAL BOARD FOR EMERGENCY CARE
APPLICATION FOR REGISTRATION

Form 24 EMB

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
application for registration as a in the category
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: R1837.00. Annual Fee: R1229.00 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

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.