

NON-COMPLIANT APPLICATION WILL BE REJECTED AND SENT BACK TO YOU!

Please PRINT and return the FORM to:

The Registrar, PO Box 205, Pretoria 0001
553 Madiba Street, Arcadia, Pretoria 0083

A. PERSONAL PARTICULARS

HPCSA Registration Number:

I, (Dr, Mr, Mrs, Miss) Surname:

Maiden name (if applicable):

First names: Identity No.:

I accept to be registered / restored in the category of supervised practiced. I undertake to work under the supervision of at as an approved facility and that my period of supervised practice will be reviewed by the relevant Professional Board upon receipt of the supervisors' report.

I further declare that I will not attempt to open a private practice or work as a locum in any other facility.

SIGNATURE: **Date:**20

B. ACCEPTANCE OF LIABILITY BY SUPERVISOR

I (Dr, Mr, Mrs, Miss): with identity number:

HPCSA Registration number: accept the responsibility to oversee professional acts to be

undertaken by Dr, Mr, Mrs, Miss: and understand that I will be held accountable during the period of supervised practice. I further undertake to submit 6 monthly supervisors reports for consideration by the relevant Professional Board.

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SIGNATURE

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PRINT NAME

.....
DATE