FORM 12

APPLICATION FOR REGISTRATION
MEDICAL PRACTITIONER PUBLIC SERVICE

NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION

Please PRINT and return the ORIGINAL FORM to:

553 Madiba Street, Arcadia, Pretoria 0083

REQUIREMENTS:

NB: The Curriculum Review Committee may require more information to enable them to arrive at a decision.	**PRACTITIONER (✓)**	**E&T COORDINATOR (✓)**
ORIGINAL APPLICATION FORM 12		
NOTARISED COPY OF DIPLOMA / DEGREE (Foreign and English translation)		
NOTARISED COPY TRANSCRIPT (Foreign and English translation)		
CERTIFIED, VALID CLEAR COPY OF PASSPORT		
PROOF OF INTERNSHIP (FORM 10 OR ORIGINAL LETTER FROM HOSPITAL WHERE INTERNSHIP WAS PERFORMED)		
VALID FOREIGN WORKFORCE ENDORSEMENT LETTER APPROVING EXAM (Issued by National Department of Health in South Africa)		
A CERTIFIED COPY OF THE OFFICIAL AND DETAILED ACADEMIC CURRICULUM OF THE APPLICANT'S COURSE OF STUDY, SPECIFYING COURSES, CONTENT OF EDUCATION (THEORY) AND TRAINING (PRACTICAL/CLINICAL), DURATION AND MODE OF EXAMINATION/EVALUATION.		
FOREIGN QUALIFIED HEALTH PRACTITIONERS WHO OBTAINED THEIR MEDICAL QUALIFICATIONS IN ANY OTHER LANGUAGE EXCEPT IN ENGLISH SHOULD SUBMIT THEIR CERTIFICATE FROM INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS). • Must achieve level 7 in each of the modules (listening, reading, academic writing, speaking)		
VALID CERTIFICATE OF GOOD STANDING – NOT OLDER THAN 6 MONTHS		
(i) either ORIGINAL CERTIFICATE Received at HPCSA; or		
(ii) ELECTRONIC COPY SEND TO hpcsacgs@hpcsa.co.za		
(iii) Applicant provides Regulator Details for HPCSA to directly retrieve electronic version from: _____		
UPDATED AND DETAILED CURRICULUM VITAE		
ECFMG REPORTS:		
• FINAL MEDICAL DIPLOMA		
• FINAL MEDICAL SCHOOL TRANSCRIPT		
• MEDICAL REGISTRATION CERTIFICATE / LICENSE TO PRACTICE		
• POSTGRADUATE MEDICAL EDUCATION CREDENTIAL (INTERNSHIP)		
• EPIC NUMBER: _____		
APPLICANT SIGNATURE:	_____	_____
MANAGER (Approver) SIGNATURE: _____	**DATE APPROVED: _____**	

A. PERSONAL PARTICULARS

Title (Prof, Dr): ……..... Surname: ……..……

Maiden Name (if applicable):.....

First name(s): .....

Passport / ID number: ……

Date of birth: ……..... Birth Place: .....

Residential address (South African):

....……

……..… Postal code: ……

Cell: ……

Tel. (Work): …….. (Home): ……

E-mail Address: ……..……..

* Marital Status: Divorced Married Single Gender: Male Female

* Race: Asian African Coloured White Country of origin: ……

SIGNATURE: …… Date: ……..… 20……

B. QUALIFICATIONS:

NAME OF DEGREE	UNIVERISTY OR INSTITUTION WHERE DEGREE / QUALIFCATION WAS OBTAINED	FROM		TO	
		MONTH	YEAR	MONTH	YEAR

DECLARATION BY APPLICANT APPLYING FOR REGISTRATION IN TERMS OF THE HEALTH PROFESSIONS ACT, 1974

I,……..hereby declare under oath as follows:

a. I am the person referred to in the accompanying certificate(s) of qualification(s) which I submit in support of my application to be registered as a Medical Practitioner in the Republic of South Africa.

b. The said qualification(s) was/were granted to me after examination and is/are my own lawful property, and entitle me as far as professional qualifications are concerned, to practise as a Medical Practitioner in the country of its/their origin, namely -
……..

c. The course of study in professional subjects which I underwent, covered a period of …….. academic years. The last …….. academic years of professional study for admission to the examination for the qualification(s) in respect of which I apply for registration, were taken at ……. (Insert name of University or Medical/Dental School).

d. I have never been convicted in any country of any offence against the law or been debarred from practice by reason of misconduct and, to the best of my knowledge and belief, no proceedings involving or likely to involve a charge of any such nature are pending against me in any country at present*.

e. I further accept that my application may be delayed should I fail to submit all the required documentation.

Signature ……..……

SWORN before me at …… this ……..day of

…… 20…….

OFFICIAL STAMP / SEAL

Signature: ……

Justice of the Peace or Commissioner of Oaths

District of……..

I, the undersigned** .....

of ..... hereby declare under oath:

I personally know .....
whose signature appears above. To the best of my knowledge and belief, the statements in his/her declaration are true.

I consider him/her to be a fit and proper person to be registered as a Medical Practitioner.

Signature:.....…… Profession or calling ……

SWORN before me at ..... ……..……this.....day of

…….. 20…….

OFFICIAL STAMP / SEAL

Signature: ……..

Justice of the Peace or Commissioner of Oaths

District of……..

I, the undersigned** .....

of ..... hereby declare under oath:

I personally know .....

whose signature appears above. To the best of my knowledge and belief the statements in his/her declaration are true.

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Signature .....

Profession or calling .....

SWORN before me at ..... this……..day of

……..… 20…….

Signature: ……

Justice of the Peace or Commissioner of Oaths

District of ……

OFFICIAL STAMP / SEAL

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* *If the applicant is unable to make the declaration above, the Council, in order to consider the application, will require full particulars of the reasons for his or her inability.*

** *The signatories should preferably be Medical Practitioners.*

HPCSA Health Professions Council of South Africa

Form 10

MEDICAL AND DENTAL PROFESSIONS BOARD HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA
INTERN DUTY CERTIFICATE – FOREIGN QUALIFIED PRACTITIONERS

As proof of completion of internship training, this form must be completed and returned to: The Registrar, Medical and Dental Professions Board, P O Box 205, Pretoria, 0001

NAME OF APPLICANT (Full names):

NAME OF ACCREDITED FACILITY:

POSTAL ADDRESS:

TITLE, INITIALS AND SURNAME OF CONTACT PERSON:

I, the undersigned, CEO/Chief Medical Superintendent of the above facility, hereby certify that the said intern completed internship training in the specified departments/domains of this facility for the periods specified, that he or she fulfilled the prescribed requirements, and that all information furnished herein is correct.

DOMAIN	**PERIOD**		**Months**	Signature of Head of Department or official deputy that the internship training had been completed **satisfactorily**
	From	**To**		
1. **MAIN CLINICAL DOMAINS** 1.1 Medicine				
1.2 Surgery				
1.3 Obstetrics and Gynaecology				
1.4 Paediatrics				
2. **ADDITIONAL CLINICAL DOMAINS** (Please specify) 2.1				
2.2				
2.3				
2.4				
3. **ANAESTHESIOLOGY (**Exact period) Number of general anaesthetics personally administered (at least 40 general anaesthetics)			No of weeks:	**Number of general anaesthetics personally administered** _____ _____ **SIGNATURE: HEAD OF DEPARTMENT OF ANAESTHETICS**
4. **LEAVE TAKEN** 4.1 Vacation leave			Total No of weeks	
4.2 Maternity leave			Total No of weeks	
4.3 Sick-leave			Total No of days	

_____ _____ _____

SIGNATURE OF CEO/CHIEF MEDICAL SUPERINTENDENT OR OFFICIAL DEPUTY **OFFICIAL STAMP OF HOSPITAL** **DATE**

NB: Please ensure that the number of general anaesthetics is correctly indicated. Omission of the number of anaesthetics and the official stamp of hospital could delay your application.