FORM 12

Health Professions Council of South Africa

APPLICATION FOR REGISTRATION IN CATEGORY FOREIGN QUALIFIED (MP) SPECIALIST ASSESSMENT THROUGH PEER REVIEW

NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION

Please PRINT and return the ORIGINAL FORM to:

553 Madiba Street, Arcadia, Pretoria 0083

REQUIREMENTS:

	PRACTITIONER (✓)	REG OFFICIAL (✓)
ORIGINAL APPLICATION FORM 12		
ORIGINAL APPLICATION FORM 21		
NOTARISED UNDERGRADUATE DIPLOMA / DEGREE (Qualifications issued in foreign language should also attach official English translation)		
NOTARISED UNDERGRADUATE TRANSCRIPT OF THE DIPLOMA / DEGREE (Qualifications issued in foreign language should also attach official English translation)		
DETAILED UNDERGRADUATE COURSE CURRICULUM		
NOTARISED SPECIALIST / SUBSPECIALIST QUALIFCATION (Foreign and English translation)		
NOTARISED TRANSCRIPT OF THE SPECIALIST QUALIFICATION (Qualifications issued in foreign language should also attach official English translation)		
DETAILED SPECIALIST TRAINING COURSE CURRICULUM		
CERTIFIED COPY OF PASSPORT		
PROOF OF INTERNSHIP (FORM 10 OR ORIGINAL LETTER FROM HOSPITAL WHERE INTERNSHIP WAS PERFORMED)		
FOREIGN WORKFORCE (in South Africa) FROM DEP OF HEALTH LETTER		
PROOF OF SPECIALIST / SUBSPECIALIST TRAINING WHICH COMPRISE: I. A certified copy of the official and detailed academic curriculum of the applicant's course of study, the specific course, the content of education (theory) and training II. Vocational / registrar training at an accredited hospital		
NOTARISED PROOF OF SPECIALIST REGISTRATION FROM COUNTRY WHERE APPLICANT IS PRACTICING		
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: _____		
DETAILED CURRICULUM VITAE		
ECFMG VERIFICATION REPORTS, CONFIRMING VERIFICATION OF: • FINAL MEDICAL DIPLOMA • FINAL MEDICAL SCHOOL TRANSCRIPT • MEDICAL REGISTRATION CERTIFICATE / LICENSE TO PRACTICE (SPECIALIST		

• POSTGRADUATE MEDICAL EDUCATION CREDENTIAL (INTERNSHIP) • POSTGRADUATE SPECIALIST / SUBSPECIALIST CERTIFICATES • EPIC NUMBER: _____		
Proof of payment of non-refundable administration fee for peer review, currently amounting currently to R_____		
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.

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…….

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.*

Health Professions Council of South Africa

Form 21

APPLICATION FOR REGISTRATION

SPECIALIST/SUB-SPECIALIST

NON COMPLIANT APPLICATION WILL BE REJECTED AND SENT BACK TO YOU

Please PRINT and return the ORIGINAL FORM to:
The Registrar, PO Box 205, Pretoria 0001 by registered mail for ease of tracking mail
553 Madiba Street, Arcadia, Pretoria 0083

1. **The application form must be completed IN DETAIL and CORRECTLY. Information regarding experience must be provided in CHRONOLOGICAL order.**
   - For registration as a **specialist,** in the case of Dentists information since qualifying as a dentist/for medical practitioners since commencement with internship.
   - For registration as a **sub-specialist,** information since registration as a specialist.
2. Attach documentary evidence in respect of **experience** and **posts** held and provide the **exact** post held and time spent in each post (beginning and end dates must be clearly indicated).
3. Additional information pertaining to your application, to which you wish to draw attention, should be provided in a separate document.
4. In order to register as a specialist, you will have to register an acceptable specialist qualification as an additional qualification against your name. (Form 19 duly completed as well as **additional qualification registration fee of R551.00.**
5. Only duly completed applications, which include the registration fee of **R7247.00** and the fee for registration of the additional qualification, if applicable.

*** 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.

PERSONAL PARTICULARS

HPCSA Registration Number: .....

Surname: .....

First names: .....

Identity Number: .....

Postal 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: .....

I declare that I have never been convicted of any criminal offence or been debarred from practice by reason of unprofessional conduct 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.

SIGNATURE: ..... **Date:** ..... **20**.....

NAME OF SPECIALITY/SUB-SPECIALITY FOR REGISTRATION IN REGISTER:

.....

QUALIFICATIONS ALREADY REGISTERED WITH THE BOARD:

.....

ANY OTHER MEDICAL/DENTAL QUALIFICATIONS HELD:

.....

PLEASE INDICATE REGISTRATION WITH OTHER MEDICAL/DENTAL COUNCIL:

.....

Date of registration: ..... **and registration status:** .....

SEE PAGE 2 FOR EXPERIENCE IN CHRONOLOGICAL ORDER (See 1. above).

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.

NB *PLEASE READ THE INSTRUCTIONS ON THE FRONT PAGE PRIOR TO COMPLETING THIS SECTION*
NO ALTERATIONS TO THIS DOCUMENT WILL BE ACCEPTED

EXPERIENCE IN CHRONOLOGICAL ORDER

Dentists starting immediately after obtaining basic qualification.
Medical practitioners starting with beginning of internship.

Name of hospital (or town/city in case of general practice)	Nature of appointment and department in which held	Full-time or Part-time	From	To	Total period in months	Supporting documentary evidence marked "A", "B", etc.

Signature of Applicant

Date

Form 12 – Foreign Specialist – Peer Review

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