

**APPLICATION FOR REGISTRATION IN CATEGORY
VOLUNTEER SERVICE**

NB: AN INCOMPLETE APPLICATION WILL BE REJECTED

Please PRINT and return the ORIGINAL FORM to:
553 Madiba Street, Arcadia, Pretoria 0083

REQUIREMENTS:

	PRACTITIONER(x)	REG OFFICIAL (x)
ORIGINAL APPLICATION FORM 12		
CERTIFIED, VALID CLEAR COPY OF PASSPORT		
NOTARISED COPY OF DIPLOMA / DEGREE		
NOTARISED COPY OF TRANSCRIPT		
PROOF OF INTERNSHIP (FORM 10 OR ORIGINAL LETTER FROM HOSPITAL WHERE INTERNSHIP WAS PERFORMED)		
VALID FOREIGN WORKFORCE ENDORSEMENT LETTER, WITH EXACT DATES (issued by National Department of Health in South Africa)		
LETTER FROM South African healthcare provider agency or any organisation recognised by the Professional Board, WITH EXACT DATES		
Valid Certificate of Good Standing		
(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:		
NAME OF REGULATOR / AUTHORITY ISSUING CERTIFICATE OF GOOD STANDING :		

CURRICULUM VITAE		
ECFMG VERIFICATION REPORTS, CONFIRMING VERIFICATION OF:		
• FINAL MEDICAL DIPLOMA		
• FINAL MEDICAL SCHOOL TRANSCRIPT		
• MEDICAL REGISTRATION CERTIFICATE / LICENSE TO PRACTICE		
• POSTGRADUATE MEDICAL EDUCATION CREDENTIAL (INTERNSHIP)		
APPLICANT SIGNATURE:	_____	_____
MANAGER (Approver) SIGNATURE:		
DATE APPROVED:		

A. PERSONAL PARTICULARS

EPIC ID / REFERENCE NUMBER:

Title (Prof, Dr): Surname:

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

First name(s):

Passport / ID number:

Date of birth: Birth Place:

Residential address (in South Africa):
.....

..... 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:

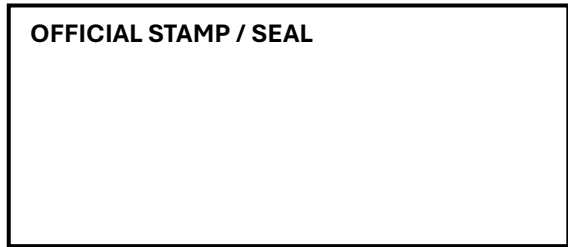
- a. I am the person referred to in the accompanying certificate(s) of qualification(s) which I submit in support of my application to be registered as a Medical Practitioner, in the category Volunteer Services in the Republic of South Africa.
- b. The said qualification(s) was/were granted to me after 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 rejected should I fail to submit all the required documentation.

Signature

SWORN before me at thisday of
..... 20.....

Signature:

Justice of the Peace or Commissioner of Oaths



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, in the category Volunteer Services..

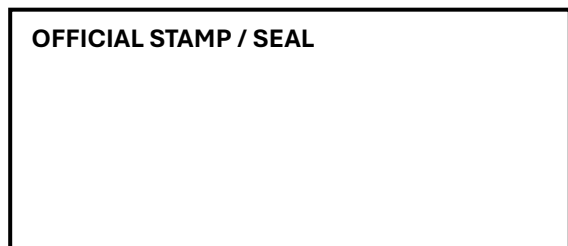
Signature:..... Profession or calling

SWORN before me atthis.....day of
..... 20.....

Signature:

Justice of the Peace or Commissioner of Oaths

District of.....



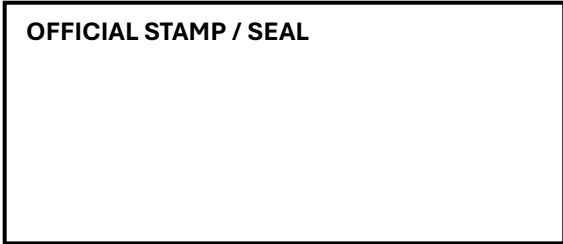
I, the undersigned**
of hereby declare under oath:
I personally know
whose signature appears above. To the best of my knowledge and belief the statements in his/her declaration are true.
I consider him/her to be a fit and proper person to be registered as a Medical Practitioner, in the category Volunteer
Services.

Signature

Profession or calling

SWORN before me at this.....day of
..... 20....

Signature:
Justice of the Peace or Commissioner of Oaths
District of



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

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



**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:	<div style="border: 2px solid black; padding: 5px;"> Number of general anaesthetics personally administered _____ SIGNATURE: HEAD OF DEPARTMENT OF ANAESTHETICS </div>
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.