Health Professions Council of South Africa

FORM 12

APPLICATION FOR REGISTRATION IN CATEGORY SPECIALIST POST TRAINING AS SUPERNUMERARY REGISTRAR

NB: AN INCOMPLETE APPLICATION WILL BE REJECTED

Please PRINT and return the ORIGINAL FORM to:

553 Madiba Street, Arcadia, Pretoria 0083

REQUIREMENTS:

NB: The applicant will be subjected to the applicable medical board exam prior to being considered for registration in the category of specialist.	**PRACTITIONER (×)**	**REG OFFICIAL (×)**
ORIGINAL APPLICATION FORM 12		
NOTARISED COPY OF UNDERGRADUATE DIPLOMA / DEGREE		
NOTARISED COPY OF TRANSCRIPT UNDERGRADUATE DIPLOMA		
DETAILED COURSE CURRICULUM		
PROOF OF INTERNSHIP (FORM 10 OR ORIGINAL LETTER FROM HOSPITALWHERE INTERNSHIP WAS PERFORMED)		
DULY COMPLETED APPLICATION FORM 21		
DULY COMPLETED ORIGINAL FORM 57		
NOTARISED COPY OF MASTERS DEGREE OR DULY COMPLETED FORM 19		
NOTARISED COPY CMSA CERTIFICATE OR DULY COMPLETED FORM 19		
ETHICS CLEARANCE CERTIFICATE		
VALID FOREIGN WORKFORCE ENDORSEMENT LETTER, WITH EXACT DATES (issued by National Department of Health in South Africa)		
PROOF OF REGISTRATION AS A MEDICAL PRACTITIONER IN THE CATEGORY SPECIALIST WITH THE REGULATING AUTHORITY IN YOUR COUNTRY.		
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)		
• ANY OTHER RELEVANT POSTGRADUATE QUALIFICATION		
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 Specialist 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 undergraduate 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 accept that my application may be rejected should I fail to submit all the required documentation. I further accept that I may be subjected to an assessment by the Board to determine my registrar.

Signature ……..……

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

…… 20……...

OFFICIAL STAMP / SEAL

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 Specialist

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, in the category Specialist

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 ……

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* *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.*

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.