



Form 23
MSIN, PHIN, GCIN

MEDICAL AND DENTAL PROFESSIONS BOARD

APPLICATION FOR REGISTRATION AS AN INTERN
MEDICAL BIOLOGICAL SCIENTIST, MEDICAL PHYSICIST,
GENETIC COUNSELLOR

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 or courier for ease of tracking mail.
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.: _____

Postal address: _____ Postal code: _____

Residential address: _____ Postal code: _____

Tel (H): _____ (W): _____

Cell: _____ Fax: _____

Email: _____

*Marital Status: Married Single Divorced Gender M F

* Race: African Asian Coloured Indian White Country of Origin: _____

hereby apply to register as _____
and declare that I am the person referred to in the attached certificate or qualification referred to below. I also 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**

B. THE FOLLOWING IS SUBMITTED IN SUPPORT OF MY APPLICATION:

- | | |
|--------------------------|---|
| <input type="checkbox"/> | 1. The original applicable application for registration, Form 26 MSIN or Form 26 PHIN or Form 26 GCIN, duly completed |
| <input type="checkbox"/> | 2. Registration fee: R540.00 Annual Fee: R1262.00 applicable from the period 1 April 2023 to 31 March 2024 . Banking details as on the website (Registration number as deposit reference) Please attach proof of payment |
| <input type="checkbox"/> | 3. A copy of my marriage certificate (should you wish to register in your married surname). |
| <input type="checkbox"/> | 4. A copy of my identity document or birth certificate. |
| <input type="checkbox"/> | 5. A copy of my registration certificate as a student with the Health Professions Council of South Africa. |

ALTERATIONS TO THIS SECTION WILL NOT BE ACCEPTED

C. TO BE COMPLETED BY THE UNIVERSITY/UNIVERSITY OF TECHNOLOGY/COLLEGE

Name of University/University of Technology/College: _____

It is hereby certified that _____ complied with all the requirements for the Degree/Diploma/Certificate _____ of this institution on _____ (day) _____ (month) _____ (year) and that this qualification will be conferred/issued at a graduation ceremony on _____ (day) _____ (month) _____ (year).

I consider him/her to be a competent and fit person to practice as a _____

WE RECOMMEND him/her for registration

ORIGINAL OFFICIAL DATE STAMP OF INSTITUTION

SIGNATURE: RECTOR/DEAN/OPERATIONAL HEAD _____ **DATE** _____

SIGNATURE: REGISTRAR/PRINCIPAL _____ **DATE** _____

* 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.