Health Professions Council of South Africa

Form 23 CA

MEDICAL AND DENTAL PROFESSIONS BOARD
APPLICATION FOR REGISTRATION
CLINICAL ASSOCIATE

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 an Clinical Associate 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:

☐	1.	Registration fee: **R1316.00** Annual Fee**: R1316.00 applicable from the period 1 April 2023 to 31 March 2024.** Banking details as on the website (**Registration number as deposit reference) <u>Please attach proof of payment</u>**
☐	2.	A copy of my marriage certificate (should you wish to register in your married surname).
☐	3.	A copy of my identity document or birth certificate.
☐	4.	A copy of my registration certificate as a student/student interen with the Health Professions Council of South Africa.
☐	5.	Non-SA Citizens: Letter of endorsement by the Foreign Workforce Management Programme of the Department of Health.

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 **DATE**	
SIGNATURE: REGISTRAR **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.