Health Professions Council of South Africa

Form 9

APPLICATION FOR REGISTRATION

AS A REGISTRAR / SUBSPECIALITY TRAINEE

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

PERSONAL PARTICULARS

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: Divorced | Married | Single Gender: Male | Female

* Race: Asian | African | Coloured | White Country of origin: .....

Hereby apply for registration / continuation of registration as a Registrar / Subspeciality Trainee

HPCSA Registration Number**:** ..... Date of First Registration**:** .....

Basic qualification**:** ..... Year obtained**:** .....

University at which currently enrolled for postgraduate sudy**:** .....

Speciality for which enrolled: .....

Subspeciality for which enrolled**:** .....

Name of Teaching / Satellite Department / Hospital**:** .....

Name of Teaching unit / Satellite teaching Unit**:** .....

Academic department**:** .....

Board approved post number**:** .....

Date of commencement of Registrar / Subspeciality Trainee course**:** .....

Current Year of Study**:** .....

SIGNATURE: ..... **DATE:** .....

REGISTRAR / SUBSPECIALITY TRAINEE

ORIGINAL OFFICIAL DATE STAMP OF INSTITUTION

.....
Signature: Dean/Head of School

.....
Date

.....
Signature: HOD/HO Unit

.....
Date

.....
Signature: Medical Superintendent

.....
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.