



**Form 18 D MT**  
Supervisory Report

**HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA**  
**PROFESSIONAL BOARD FOR MEDICAL TECHNOLOGY**

**REPORT BY SUPERVISOR**  
**FOLLOWING COMPLETION OF PERIOD OF SUPERVISED PRACTICE**

**APPLICANT**

Registration Number

Title (Mr, Mrs, etc.), Initials and Surname

Date of Erasure (For office use only)

Date of Restoration (For office use only)

Postal Address

Telephone		Cell Number	
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E-Mail Address	
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**SUMMARY OF APPLICANT'S ACTIVITIES AND EMPLOYMENT SINCE RESTORATION OF NAME TO THE REGISTER OF SUPERVISED PRACTICE**

Name of Institution	Activities performed	From		To	
		Month	Year	Month	Year

<b>SUPERVISING PRACTITIONER</b>	
<b>Title, Initials and Surname</b>	
<b>Registration number</b>	
<b>Registered with the HPCSA since</b>	
<b>Laboratory</b>	
<b>Telephone</b>	
<b>Cell Number</b>	
<b>E-Mail Address</b>	
<b>Fax Number</b>	

<b>SUMMARY AND RECOMMENDATIONS</b>	<i>Independent Practice Advised?</i>	
	<b>YES</b>	<b>NO</b>

It is hereby confirmed that the applicant had completed work under my supervision for a period equivalent to at least six months (1000 hours) from  
 .....20.....  
 to .....20.....

**SUPERVISING PRACTITIONER**

<b>Title, Initials and Surname</b>	
<b>Signature</b>	
<b>Date</b>	

**SUPERVISEE**

<b>Title, Initials and Surname</b>	
<b>Signature</b>	
<b>Date</b>	