



APPLICATION FOR REGISTRATION
PROFESSIONAL BOARD FOR MEDICAL TECHNOLOGY

Form 24 LA

LABORATORY ASSISTANT

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, (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 as a Laboratory Assistant in the category:
and hereby make oath and declare that I am the person mentioned.

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

SWORN BEFORE ME AT: this day of 20

SIGNATURE:

COMMISSIONER OF OATHS/JUSTICE OF PEACE for the district of

B. The following is submitted in support of my application:

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

- 1. Copy of letter from the SMLTSA indicating that the examination was passed during ...20.....
2. Form 25 duly completed.
3. Registration fee: R916.00 Annual Fee: R730.00 applicable from the period 1 April 2024 to 31 March 2025. Banking details as on the website (Registration number as deposit reference) Please attach proof of
4. A copy of my identity document or birth certificate.
5. A copy of my marriage certificate (should you wish to register in your married surname).
6. A copy of my certificate as a student with the Health Professions Council of South Africa.

C. CERTIFICATE OF HEALTH

I, of (address) a registered medical practitioner, the applicant, and I declare that his/her health is

certify that I have medically examined such that it would not be detrimental to patients or to him-/herself to engage in the duties of his/her profession.

SIGNATURE: Date: 20

D. CERTIFICATE OF CHARACTER

I, (full names): of address

Working as (Medical Practitioner, Minister of Religion, Magistrate or other responsible person) certify that

the applicant, is personally known to me and that he/she is of good character.

SIGNATURE: Date: 20

\* 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.