Form 25

HEALTH PROFESSIONS COUNCIL OF SOUTH-AFRICA

PROFESSIONAL BOARD FOR MEDICAL TECHNOLOGY

MTIN-…………………………

GT-S …………………………..

LA S …………………………..

NB please take note that the Council, in the normal course of its duties, reserves the right to divulge information in your personal file to other parties.

NAME OF LABORATORY: ………..

POSTAL ADDRESS OF LABORATORY: ………

……………………………………………………………………….. Code and Tel No. ……………………………………………………………………

NAME OF HEAD OF LABORATORY:

DR/MR/MRS/MISS ………

It is hereby certified that Mr/Mrs/Miss ………………………………………………………………………………………………………
has served this training establishment for the periods specified as trainee Medical Technologist/Technician in the categories/departments indicated, that this institution is accredited for training in the specified categories and that he/she has fulfilled the prescribed requirements.

CATEGORY/DEPARTMENT	PERIOD		Number of months	SIGNATURE OF HEAD OF LABORATORY OR DEPUTY	SIGNATURE OF CHIEF MEDICAL TECHNOLOGIST OR DEPUTY
	From month and year	To month and year			
		TOTAL:			

OFFICIAL DATE STAMP OF LABORATORY		**Return the ORIGINAL FORM duly completed together with form 24MT or 24GT to:** **The Registrar** **HPCSA** **P O Box 205** **PRETORIA, 0001**

updated/MM/2023