

**HEALTH PROFESSIONS COUNCIL  
OF SOUTH AFRICA**

**PROFESSIONAL BOARD FOR OPTOMETRY AND  
DISPENSING OPTICIANS**

**APPLICATION FOR APPROVAL OF A MOBILE PRACTICE**

**SECTION A: THE APPLICATION PROCESS**

1. This is the application form which should be submitted to the Board when applying for approval of a mobile practice.
2. Applications for approval of mobile practices will only be considered and approved by the Board in accordance with:
  - a. The ethical rules of conduct for practitioners registered under the Health Professions Act 56, 1974, as amended
  - b. Guidelines of the Professional Board for Optometry and Dispensing Opticians on vision screening, itinerant practices and mobile clinics.
3. The application form must be completed in full and honestly.
4. The practice could be investigated or inspected by the Board prior to approval, and from time to time thereafter. Action will be taken if a practitioner fails to comply with the stipulations in the Ethical Rules and ethical principles applied by the Board and Council.
5. The approval granted by the Board for mobile practice is **valid for two (2) years only** and should the practitioner wish to continue offering this service he/she must re-apply in good time before the original expires.
6. Operating a mobile practice without having obtained the Board's approval will result in appropriate action being taken against the practitioner.
7. The application form must be submitted together with the following documents:
  - Completed equipment checklist
  - Completed equipment maintenance register
  - Sample of record card to be used

**SECTION B: PARTICULARS OF APPLICANT**

Title: \_\_\_\_\_

Full name and Surname: \_\_\_\_\_

HPCSA Registration Number: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
\_\_\_\_\_

Postal Address: \_\_\_\_\_  
\_\_\_\_\_

Name of Practice: \_\_\_\_\_

Practice Address: \_\_\_\_\_  
\_\_\_\_\_

Practice Tel Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**SECTION C: PARTICULARS OF MOBILE PRACTICE**

a. Definition of the area/areas where mobile practice will be operated (Province, town/city, village/location/suburb):

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b. Physical Address of the area/areas where mobile practice will be operated:

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c. Distance in kilometres from the applicant(s) established practice to the area/areas where mobile practice will be operated:

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d. State the specific motivation for the need of a mobile practice in your chosen area/areas; Tick the appropriate reason:

No Optometry services at the Hospital in the area		No eye health practice nearby	
Request by company/organisation Provide the following: <ul style="list-style-type: none"> <li>• The reasons for the request</li> <li>• Is it a once-off arrangement or ongoing</li> </ul>		To reach-out to the community and also expand business	
Other		Provide explanation if other: <hr/> <hr/> <hr/>	

e. Provide the following information:

1. Brief description of the mobile unit/service for which approval is being sought (vehicle/permanent structure).

If vehicle - provide type of vehicle and registration number:

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If permanent structure – Name and address of the place from which the mobile practice will operate (school/organisation etc ):

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2. How will the equipment be packaged or stored while in-transit?

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3. Schedule for mobile eye care services to identified areas (Provide month/s, day/s & operation time/s), including the after-care plan:

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4. Names and HPCSA registration numbers of all optometrists/dispensing opticians who will be involved in rendering of the mobile eye care services?

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5. Closest optometric or other eye care private practice or facility providing similar services (Provide name, address and distance in kilometres from area/s that this application will cover)

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6. Closest state facility providing eye care services (Provide name, address and distance in kilometres from the area/s that this application will cover).

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7. Please attach MoU with a healthcare facility/practitioner who will provide follow up care or services in the absence of the applicants mobile service/s.

**SECTION D: OTHER INFORMATION:**

Please provide any other relevant information pertaining to the application.

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**SECTION E: DECLARATION**

I, \_\_\_\_\_, in my capacity as  
(Full names and Surname)

\_\_\_\_\_ in relation to the mobile  
practice referred to above understand, confirm and agree that –

- a. approval of this application for conducting mobile practice is based on information provided by me as the applicant, and I undertake to furnish the Board with any other additional information as may be required and to inform the Board should any of the particulars detailed above change;
- b. the practice has been designed and will operate in accordance of the appropriate HPCSA regulations.
- c. I will at all times abide by the Ethical Rules of conduct for practitioners registered under the Health Professions Act 56, 1974, as amended;
- d. the practice may be investigated or inspected by the Board from time to time and action taken if failure to comply with the stipulations in the Ethical Rules and ethical principles of the Board and the HPCSA is identified.
- e. costs incurred during an inspection from the HPCSA will be born by myself (the applicant) and will be charged on a cost-recovery basis.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness (Signature): \_\_\_\_\_

Date: \_\_\_\_\_

**SECTION D: APPLICATIONS FOR APPROVAL OF MOBILE PRACTICE**

Duly compiled applications or written enquiries may be addressed to the Registrar and posted to HPCSA, P O Box 205, Pretoria, 0001; or hand delivered to: the HPCSA, 553 Madiba Street, Arcadia, Pretoria; or faxed to: 012 338 9421; or emailed to: [ODOboard@hpcsa.co.za](mailto:ODOboard@hpcsa.co.za)