



APPLICATION FOR REGISTRATION
PROFESSIONAL BOARD FOR CLINICAL TECHNOLOGY

Form 24 KT

CLINICAL TECHNOLOGIST

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 Clinical Technologist in the category:
and hereby make oath and declare that I am the person mentioned in the attached documents submitted by me in support of my application for registration and that all the said documents were granted to me and are my own lawful property; and further, that I have never been debarred from practicing in any country by reason of misdemeanor or professional misconduct.
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:

Vertical list of boxes for document submission

- 1. My original diploma (a copy will only be accepted if certified by an attorney in his/her capacity as Notary Public and bearing the official stamp, or Form 23, duly completed.) Copies certified by a Commissioner of Oaths will not be accepted.
2. Registration fee: R934.00 Annual Fee: R1595.00 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 payment
3. A copy of my identity document or birth certificate.
4. A copy of my marriage certificate (should you wish to register in your married surname).
5. A copy of my certificate as a student with the Health Professions Council of South Africa.

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

C. CERTIFICATE OF HEALTH

I, _____ of (address) _____ a registered medical practitioner,

certify that I have medically examined _____ the applicant, and I declare that his/her health is 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.