



**Form 18 PPB
Portfolio**

HEALTH PROFESSIONS OF SOUTH AFRICA

PROFESSIONAL BOARD FOR PHYSIOTHERAPY, PODIATRY AND BIOKINETICS

PORTFOLIO FOLLOWING COMPLETION OF PERIOD OF SUPERVISED PRACTICE

APPLICANT

Registration Number				
Title (Mr, Mrs, etc.), Initials and Surname				
Telephone				
Cellphone				
E-mail				
Date of Erasure (For office use only)				
	< 6 months	> 6 months < 1 year	1 – 2 years	> 2 years
Date of Restoration (For office use only)				

SUMMARY OF ACTIVITIES, EMPLOYMENT OR UNEMPLOYMENT SINCE RESTORATION OF NAME TO THE REGISTER OF SUPERVISED PRACTICE:

Name of Institution / Practice / Hospital	Hours	From		To	
		Month	Year	Month	Year

INFORMATION REGARDING SUPERVISING PRACTITIONER*	
Title, Initials and Surname	
Registration number	
Date first registered with the HPCSA	
Name of practice / institution / hospital	
Designation / post status	
Tel / Fax no	
Cellphone no	
E-mail	

* If more than one supervisor, please complete one form for each supervisor

CASE REPORT SUBMITTED (refer to the guidelines regarding the format/structure of the case study for each profession)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
CPR (First Aid Level 1) CERTIFICATE SUBMITTED	YES <input type="checkbox"/>	NO <input type="checkbox"/>

SUMMARY OF PATIENTS TREATED BY APPLICANT

CONDITION / DIAGNOSIS	DIAGNOSTIC / ASSESSMENT TOOLS USED	DETAILS OF Rx TECHNIQUES / MODALITIES USED	SIGNATURE: SUPERVISOR

CPD RECORD (refer to the guidelines for CEU requirements)

CPD ACTIVITY	DATE	LEVEL	NUMBER OF CEU'S
Total points			

I hereby declare that the information contained in this document is to the best of my knowledge correct.

SIGNATURE: SUPERVISING PRACTITIONER	DATE
SIGNATURE: APPLICANT	DATE