



PROFESSIONAL BOARD FOR DENTAL THERAPY AND ORAL HYGIENE

APPLICATION FOR REGISTRATION

Form 24 TT

AS A DENTAL THERAPIST

NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION

Please PRINT and return the ORIGINAL FORM to: The Registrar, PO Box 205, Pretoria 0001 553 Vermeulen 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 make oath and declare that I am the person mentioned in the attached documents submitted by me in support of my application and declare 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 professional misconduct 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. (Full particulars of the reason for your inability to do so will be required if you are unable to make this declaration.)

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

Four empty rectangular boxes for document submission.

- 1. My original certificate (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: R820.00 Annual Fee: R2170.00 applicable from the period 1 April 2021 to 31 March 2022. 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).

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

* 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.