Health Professions Council of South Africa

Form 11 C

MEDICAL AND DENTAL PROFESSIONS BOARD
APPLICATION FOR REGISTRATION
INDEPENDENT PRACTICE – (MEDICAL PRACTITIONER)

NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION

Please PRINT and return the DULY COMPLETED FORM per registered mail or per courier to:

The Registrar, PO Box 205, Pretoria 0001
553 Vermeulen Street, Arcadia, Pretoria 0083

FOR OFFICE USE ONLY

A. PERSONAL PARTICULARS

HPCSA Registration Number: .....

I, Dr, 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 to be registered as a Medical Practitioner in the category Independent Practice after having completed a period in public service and 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** .....

Received on .....

MP: .....

Reg. Date .....

VERIFIED .....

DATE .....

CAPTURED .....

DATE .....

VERIFIED .....

DATE .....

B.1. In support of my application I attach hereto **my permamnent residence permit and a copy of my South African identity document.**

2. Proof of ECFMG verification report confirming verification of my **medical degree, transcript and registration with any other medical authority where I practiced my profession outside the Republic of South Africa.**

3. Attach proof of passing the assessment by the Medical and Dental Board (i.e. Board exam OR final year University exam with the Republic of South Africa).

4. Attach an official service record of not less than 5 years in public service indicating **the name of the Hospital, your persal number and period(s) in public service, issued by the Human Resource Department** of the hospital(s) where you worked in public service.

*** 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.