Health Professions Council of South Africa

Form 14 A

APPLICATION FOR REGISTRATION
MEDICAL AND DENTAL PROFESSIONS BOARD
DENTIST IN THE CATEGORY COMMUNITY SERVICE

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, (Prof, 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 register as a dentist in the category community service.

SIGNATURE: ..... **Date:** ..... **20** .....

B. The following is submitted in support of my application:

☐	1.	Registration fee: **R3300.00** Annual Fee: **R2890.00 applicable from the period 1 April 2021 to 31 March 2022**. Banking details as on the website (**Registration number as deposit reference) <u>Please attach proof of payment</u>**
☐	2.	A copy of my identity document or birth certificate.
☐	3.	A copy of my marriage certificate (should you wish to register in your married surname).
☐	4.	Non-SA Citizens: Letter of endorsement by the Foreign Workforce Management Programme of the Department of Health.
☐	5.	A certified copy of a letter of appointment to perform Community Service at an approved institution, issued by the Department of Health.
☐	6.	A copy of my registration certificate as a student with the Health Professions Council of South Africa.

C. TO BE COMPLETED BY THE UNIVERSITY

Name of University: .....

It is hereby certified that ..... complied with all the requirements for the Degree ..... of this University on ..... (day) ..... (month) ..... (year) and that this qualification will be conferred/issued at a graduation ceremony on ..... (day) ..... (month) ..... (year).

WE RECOMMEND him/her for registration as a dentist

ORIGINAL OFFICIAL DATE STAMP OF INSTITUTION

....

SIGNATURE: RECTOR/DEAN/OPERATIONAL HEAD **DATE**

....

SIGNATURE: REGISTRAR/PRINCIPAL **DATE**

*** 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.

Updated/MM/March 2021