



Form 23 IN

**MEDICAL AND DENTAL PROFESSIONS BOARD
APPLICATION FOR REGISTRATION
INTERN IN MEDICINE**

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, (Dr, 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: Married Single Divorced Gender M F

* Race: African Asian Coloured Indian White Country of Origin: _____

hereby apply to register as an Intern in Medicine and declare that I am the person referred to in the attached certificate or qualification referred to below. 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**

B. THE FOLLOWING IS SUBMITTED IN SUPPORT OF MY APPLICATION:

- | | |
|--|---|
| | 1. Registration fee: R500.00 Annual Fee: R1170.00 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 |
| | 2. A copy of my marriage certificate (should you wish to register in your married surname). |
| | 3. A copy of my identity document or birth certificate. |
| | 4. A copy of my registration certificate as a student/student interen with the Health Professions Council of South Africa. |
| | 5. Non-SA Citizens: Letter of endorsement by the Foreign Workforce Management Programme of the Department of Health. |

ALTERATIONS TO THIS SECTION WILL NOT BE ACCEPTED

C. TO BE COMPLETED BY THE UNIVERSITY/UNIVERSITY OF TECHNOLOGY/COLLEGE

Name of University/University of Technology/College: _____

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

I consider him/her to be a competent and fit person to practice as a _____

WE RECOMMEND him/her for registration	ORIGINAL OFFICIAL DATE STAMP OF INSTITUTION
SIGNATURE: RECTOR/DEAN _____ DATE _____	
SIGNATURE: REGISTRAR _____ 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.