Form 39

MEDICAL AND DENTAL PROFESSIONS BOARD

APPLICATION FOR REGISTRATION

STUDENT INTERN

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 for ease of tracking mail
553 Madiba 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: ....

I hereby apply to register as a student intern in ……………………………..………………………………………

I 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 of **R531.00 applicable from 1 April 2022 to 31 March 2023**. Banking details as on the website. This fee must be remitted by a bank draft drawn on a bank in South Africa. (**Use Registration number as deposit reference)**

☐ 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. A copy of my registration as a student with the Health Professions Council of South Africa.

(NO ALTERATIONS TO THIS SECTION WILL BE ACCEPTED)

C. TO BE COMPLETED BY THE UNIVERSITY

Name of University ....

It is hereby certified that ....

has completed and passed at least 5 years' study as a medical student.

We recommend that he/she be registered as a medical student intern and consider him/her to be a competent and fit person to practice

		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.