



PROFESSIONAL BOARD FOR OCCUPATIONAL THERAPY, MEDICAL ORTHOTICS & PROSTHETICS & ARTS THERAPY

Form 24 OTT

APPLICATION FOR REGISTRATION AS AN OCCUPATIONAL THERAPY TECHNICIAN

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, (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: Divorced Married Single Gender: Male Female
* Race: Asian African Coloured White Country of origin:
Hereby apply to register as and declare that I am the person referred to in the certificate below. Further, I have never been convicted of any criminal offence or been debarred from practising my profession in any country by reason of a criminal offence or unprofessional conduct and 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: R772.00 Annual Fee: R574.00 applicable from the period 1 April 2022 to 31 March 2023. Banking details as on the website (Registration number as deposit reference) Please attach proof of payment.
2. Documentary evidence of having successfully completed the examination of the Board;
3. A copy of my occupational therapy assistant (OTB) registration certificate with the Health Professions Council of South Africa.
4. A copy of my identity document or birth certificate.
5. 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

D. CERTIFICATE OF CHARACTER

I, (full names): of address. Working as (Medical Practitioner, Minister of Religion, Magistrate or other responsible person) certify that the applicant, is personally known to me and that he/she is of good character.
SIGNATURE: Date: 20

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.