PROFESSIONAL BOARD FOR DENTAL THERAPY AND ORAL HYGIENE

APPLICATION FOR REGISTRATION

ORAL HYGIENIST (EXTENDED FUNCTION)

Health Professions Council of South Africa

Form 24 OH

NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION

Please PRINT and return the ORIGINAL FORM to: The Registrar, PO Box 205, Pretoria 0001
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: .....

Hereby make oath and declare that I am the person mentioned in the attached documents submitted by me in support of my application for registration as a ..... in the category .....

and that all the said documents were granted to me and are my own lawful property. Further, that I have never been debarred from practicing in any country by reason of misdemeanor or professional misconduct.

I further 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** .....

SWORN BEFORE ME AT ..... this ..... day of ..... **20** .....

SIGNATURE: .....

COMMISSIONER OF OATHS/JUSTICE OF PEACE for the district of .....

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

	1. My original diploma/degree (a copy will only be accepted if certified by an attorney in his/her capacity as **Notary Public** and bearing the official stamp, **OR** Form 23, duly completed.) Copies certified by a Commissioner of Oaths **will not be accepted**.
	2. Current registation fee; plus the pro rata annual fee obtainable from the HPCSA Call Centre at 012 338 9300. Please attach a copy of the proof of payment.
	3. A copy of my identity document or birth certificate.
	4. A copy of my marriage certificate (should you wish to register in your married surname).
	5. A copy of my certificate as a student with the Health Professions Council of South Africa.

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

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** .....

*** 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.