

**HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA PROFESSIONAL BOARD FOR  
MEDICAL TECHNOLOGY APPLICATION FOR APPROVAL TO CONDUCT A PRIVATE  
PRACTICE**

**REQUIREMENTS**

1. Each application for approval to conduct a private practice has to be considered by the Professional Board.
2. In order to comply with the requirements, an applicant has to provide proof of at least two (2) years post registration experience in the particular category of registration.

The following **ORIGINAL** documentation must be submitted in support of your application for approval to conduct a private practice:

- a. The enclosed application form (Form 133) duly completed;
- b. **AN ORIGINAL LETTER** from your employer confirming that you have at least two (2) years post registration experience in medical technology in the particular category;
- c. Certified Extract certificate from the register for purposes of registration of a practice number at the Board of Healthcare Funders of South Africa. Please also reflect your MT registration number on the deposit slip.
- d. Proof of payment of annual fee
- e. Proof of compliance to CPD requirements

Banking details are as follows:

ABSA Bank                      Arcadia  
Branch code:                    334945  
Account number:                061 00 00 169

**NOTE: THE APPLICATION TAKES 6 – 7 WEEKS FOR APPROVAL**

Please note that in terms of the ethical rules (copy attached) you may only practise in your personal capacity and may **NOT** link any name such as hospital, clinic, laboratory etc to your practice name. You may reflect the category of registration such as Microbiology, Clinical Pathology etc. **Examples: Ms Dorothy Daniels Medical Technologist or D Daniels Medical Technologist (Microbiology) etc.**

**HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA PROFESSIONAL BOARD FOR  
MEDICAL TECHNOLOGY APPLICATION: PRIVATE PRACTICE**

1. TITLE:(MR/MRS/MISS):..... MT.....
2. INITIALS AND SURNAME:  
.....
3. REGISTERED  
ADDRESS:.....  
.....  
.....
4. TEL: (W)..... (H) .....
- E-MAIL ADDRESS .....
5. DATE OF REGISTRATION:  
.....

Category	Date of Registration
1.	...../...../.....
2.	...../...../.....
3.	...../...../.....

6. QUALIFICATION(S) AND DATE(S) OBTAINED:  
..... /..... /.....  
..... /..... /.....  
..... /..... /.....
7. POST-REGISTRATION EXPERIENCE (Including past five years): **(Attach supporting documentation)**

Laboratory	From	To

8. MEMBERSHIP OF PROFESSIONAL SOCIETIES:
- |  | From | To |
|--|------|----|
|  |      |    |


9. NAME OF PROPOSED PRACTICE/PARTNERSHIP: (See Rule 4 of Ethical Rules)

.....  
 .....  
 .....

10. NATURE OF PRACTICE

**(Note: Each partner must apply individually)**

- Solo  Practice
- Partnership\*
- Section  54A Company\*

\*Names of Partners / directors and: shareholders

.....  
 .....

11. CATEGORY/IES IN WHICH YOU WISH TO PRACTICE:  
**(Note: Only registered categories will be considered)**

.....  
 .....  
 .....

12. STREET ADDRESS AND TELEPHONE NUMBER OF PROPOSED LABORATORY:

.....  
 .....  
 .....

TELEPHONE: .....

13. STATEMENT BY APPLICANT:

I hereby certify that -

- i. the information given in this application is to the best of my knowledge correct;
- ii. I will not engage in independent practice until the Professional Board has approved my application;
- iii. I accept my sole responsibility to be fully conversant with the medical and legal regulations and requirements for independent practice.

-Documents referred to in paragraph 7 above are attached hereto.

SIGNATURE: .....

DATE: .....

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Update:2014 04 05 LS