Form CPD 2A	APPLICATION FOR APPROVAL OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD) ACTIVITIES

Please complete and submit this application to a Profession-specific Accreditor
NOTE: The Programme for the Activity and the Presenter's CV must be submitted with this application preceding the activity. No retrospective approval will be made.

Name of Providing Organisation/Provider (Including Registration Number)		
Postal Address of Providing Organisation/Provider		
Target Audience		
Contact Person (Providing Organisation/Provider)		
Telephone Number (Including Area Code) (Providing Organisation/Provider)		
Fax Number (Including Area Code) (Providing Organisation/Provider)		
e-Mail Address (Providing Organisation/Provider)		
Activity Title		
The potential of the activity to enhance professional performance **(Required for reporting to HPCSA))**		
Date(s) of Activity/Programme		
Venue (Full Address) of Activity (If Applicable)		
	Postal code	
Level of Proposed CPD Activity		
Registration Fee involved for participants		
Duration of the learning activity (hours)		
Suggested CEU's (General)	**Level 1**	**Level 2**
Suggested CEU's in Medical Ethics, Human Rights and Legal Issues pertaining to health sciences	**Level 1**	**Level 2**

Suggested number of CEU's (Indicate Maximum CEUs in each Level)	**Level 1**	**Level 2**
Specify intended method of evaluation (e.g. Questionnaire		
Specify the intended mechanism for monitoring attendance (per hour or per session) for the duration of the activity		
Have you applied to another accreditor to have this activity approved? If yes, to whom and what was the outcome? Provide reason if the application was not approved.	Name of Accreditor: No. Outcome and reason	

Organisations/Providers:

With the submission of this application, I

a. submit my advertisement
b. declare that the activity would not be advertised without prior approval of the Accreditor
c. undertake to monitor the attendance for the duration of the activity
d. evaluate the presentations as specified and to inform the accreditors accordingly
e. recognize the authority of the Board/Accreditors to cancel the accreditation in the event of non-compliance with the criteria.

Signature:
Designation: **Date:**

FOR THE OFFICIAL USE OF THE ACCREDITOR

This is to certify that …….(name of Accreditor) -

has agreed to the proposed CPD CEUs as follows:

Level 1	Level 2	Level 3	Ethics/Human Rights/Legal Matters

Specify ethical/human rights/health law relating to health sciences

TOTAL:

Specify the reasons why the learning activity has not been accredited:

…….

SIGNATURE ON BEHALF OF DESIGNATED CPD ACCREDITOR

DATE:

NAME AND DESIGNATION:	

Update: 23 June 2016