



Form 23 DOH

PROFESSIONAL BOARD FOR DENTAL THERAPY AND ORAL HYGIENE

APPLICATION FOR REGISTRATION

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 OR per courier.**
553 Madiba Street, Arcadia, Pretoria 0083

FOR OFFICE USE ONLY

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** _____

Received on _____

Amount _____

Receipt No. _____

No. _____

Reg. Date _____

I certify that the application meets the requirements as outlined in section B and that I have verified the application:

Registration Officer:

Signature:

Date:

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

1. Current registration fee of **R697.00** 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.
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 certificate as a student with the Health Professions Council of South Africa.

C. TO BE COMPLETED BY THE UNIVERSITY/TECHNIKON/COLLEGE NO ALTERATIONS TO THIS DOCUMENT WILL BE ACCEPTED.**

Name of University/University of Technology/College: _____

It is hereby certified that _____ complied with all the requirements for the Degree/Diploma/Certificate _____ of this institution on _____ (day) _____ (month) _____ (year) and that this qualification will be conferred/issued at a graduation ceremony on _____ (day) _____ (month) _____ (year).

WE RECOMMEND him/her for registration

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.