Form 18

APPLICATION FOR RESTORATION OF NAME TO THE REGISTER IN TERMS OF SECTION 19(5) OF THE HEALTH PROFESSIONS ACT, 1974 (ACT No. 56 OF 1974)

NON COMPLIANT APPLICATION WILL BE REJECTED AND SENT BACK TO YOU!

Please PRINT and return the FORM to:
The Registrar, PO Box 205, Pretoria 0001 by registered mail for ease of tracking mail
553 Madiba Street, Arcadia, Pretoria 0083

BANKING DETAILS:

Bank: ABSA
Branch: Arcadia
Branch Code: 632005
Account Type: Cheque Account
Account number: 405 00 33 481 (Annual fees only)
Account Number: 061 00 00 169 (All other fees)

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

Registration Officer: ....

Signature: ....

Date:

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: ....

I request that my name be restored to the register of ………………………………………. for the Republic of South Africa and hereby make oath and declare that I was registered as a …………………………………..………………. with the registration number …………………….
My name was suspended from the register under Section 19 of the Act.
I also delcare 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...........**
PRACTITIONER

……………………………………………………….……………   ……………………………
SIGNATURE   **DATE**
TO BE COMPLETED BY COMMISSIONER OF OATHS

ORIGINAL OFFICIAL STAMP OF COMMISSIONER OF OATHS

** If you are unable to make the declaration in this paragraph, the Council requires full particulars of the reason for your inability to do so in order to consider the application.

B. THE FOLLOWING IS SUBMITTED IN SUPPORT OF MY APPLICATION:

☐ 1. The amount of ……………………………………… in respect of my application for restoration.
☐ 2. A copy of my marriage certificate (should you wish to register in your married surname).
☐ 3. Please fax your application form and proof of payment to (012) 328 5120

*** 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.

FURTHER DOCUMENTATION TO BE SUBMITTED IN ADDITION TO THE REQUIREMENTS REFLECTED ABOVE

Restoration following voluntary erasure or erasure due to non-payment of annual fees:

- A summary of activities, employment and non-employment within and outside the profession during the period of erasure (Template attached hereto).

- Original documentary evidence of work experience issued by the relevant employers. Evidence regarding experience and appointments held must specify the exact nature and extent of work performed and the periods during which the appointments were held

- A summary of CPD activities completed during the period of erasure as per the Continuing Professional Development policy of Council (Template attached hereto).

- Original documentary evidence regarding undergraduate and / or postgraduate studies since erasure from the register in South Africa (if applicable).

- If the applicant was registered outside South Africa since erasure of his/her name from the register, a recent original Certificate of Status (Certificate of Good Standing), indicating that the applicant is in good standing, issued by the foreign registration authority within the preceding three months.

Form 18 PPB
Application for Restoration

HEALTH PROFESSIONS OF SOUTH AFRICA

PROFESSIONAL BOARD FOR PHYSIOTHERAPY, PODIATRY AND BIOKINETICS

APPLICATION FOR RESTORATION OF NAME TO THE REGISTER

APPLICANT
Registration Number
Title (Mr, Mrs, etc.), Initials and Surname
Date of Erasure (For office use only)
SUMMARY OF ACTIVITIES, EMPLOYMENT OR NON-EMPLOYMENT SINCE ERASURE OF NAME FROM THE REGISTER:

Activities / Name of Institution	**Nature of appointment held**	**From**		**To**	
		Month	**Year**	**Month**	**Year**

SUMMARY OF ACTIVITIES, EMPLOYMENT OR NON-EMPLOYMENT SINCE ERASURE OF NAME FROM THE REGISTER:					
Activities / Name of Institution	Nature of appointment held	From		To	
		Month	Year	Month	Year

CPD ACTIVITIES ATTENDED DURING PAST TWO YEARS

CPD ACTIVITY	LEVEL	NUMBER OF CEU'S
Total points		

FURTHER STUDIES UNDERTAKEN SINCE ERASURE OF NAME FROM THE REGISTER

QUALIFICATION / COURSE	NATURE AND RELEVANCE	DATE STARTED	DATE COMPLETED

DETAILS OF ADDITIONAL READING UNDERTAKEN SINCE ERASURE OF NAME FROM THE REGISTER

TITLE OF PUBLICATION	NATURE AND RELEVANCE	PERIOD

I hereby declare that the information contained in this document is to the best of my knowledge correct and accept that I may be required to meet specific requirements in order to have my name restored to the register.

SIGNATURE: APPLICANT	DATE

Form 18 PPB
Portfolio

HEALTH PROFESSIONS OF SOUTH AFRICA

PROFESSIONAL BOARD FOR PHYSIOTHERAPY, PODIATRY AND BIOKINETICS

PORTFOLIO FOLLOWING COMPLETION OF PERIOD OF SUPERVISED PRACTICE

APPLICANT
Registration Number
Title (Mr, Mrs, etc.), Initials and Surname
Date of Erasure (For office use only)
Date of Restoration (For office use only)
SUMMARY OF ACTIVITIES, EMPLOYMENT OR UNEMPLOYMENT SINCE RESTORATION OF NAME TO THE REGISTER OF SUPERVISED PRACTICE:

Activities / Name of Institution	Nature of appointment held	From		To	
		Month	Year	Month	Year

INFORMATION REGARDING SUPERVISING PRACTITIONER	
Title, Initials and Surname	
Registration number	
Registered with the HPCSA since	
Current employment	
Telephone	
Fax Number	
Cell Number	
E-Mail Address	

CONTACT DETAILS OF APPLICANT APPLYING FOR THE RESTORATION OF NAME TO THE REGISTER	
Title, Initials and Surname	
Telephone	
Cell Number	
E-Mail Address	

SUMMARY OF CASES TREATED BY APPLICANT

CONDITION / DIAGNOSIS	DIAGNOSTIC / ASSESSMENT TOOLS USED	DETAILS OF RX MODALITIES USED	SIGNATURE: SUPERVISOR

SUMMARY OF CASES TREATED BY APPLICANT (CONTINUED)

CONDITION / DIAGNOSIS	DIAGNOSTIC / ASSESSMENT TOOLS USED	DETAILS OF RX MODALITIES USED	SIGNATURE: SUPERVISOR

CPD ACTIVITIES ATTENDED SINCE RESTORATION OF NAME TO THE REGISTER

CPD ACTIVITY	LEVEL	NUMBER OF CEU'S
Total points		

I hereby declare that the information contained in this document is to the best of my knowledge correct and that the applicant meets the minimum requirements of the Board relating to clinical competence to safely practise the profession.

SIGNATURE: SUPERVISING PRACTITIONER	**DATE**
SIGNATURE: APPLICANT	**DATE**

First application for Restoration - PPB