PROFESSIONAL BOARD FOR DENTAL THERAPY AND ORAL HYGIENE

APPLICATION FOR REGISTRATION

RE-REGISTRATION AS STUDENT – DENTAL THERAPIST

Health Professions Council of South Africa

Form 53 (TT-S)

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.
553 Madiba Street, Arcadia, Pretoria 0083

FOR OFFICE USE ONLY

Received on .....

Amount .....

Receipt No. .....

VERIFIED .....

DATE .....

CAPTURED .....

DATE .....

VERIFIED .....

DATE .....

Bank Details:

HPCSA
Bank:
ABSA
Branch:
Arcadia
Branch code:
334945
Acc. No.
0610000169

To be duly completed by the student.

A. PERSONAL PARTICULARS

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 apply to register as a Student in ..... and declare that I am the person referred to in the attached documents submitted by me in support of my application and that all the said documents were granted to me and are my lawful property.

SIGNATURE: ..... **DATE:** ..... **20**.....

B. The following is submitted in support of my application for RE-REGISTRATION after interruption of studies for ONE YEAR or MORE:

- ☐ 1. Registration fee of **R108.00.** Please attach a copy of the proof of payment.
- ☐ 2. A copy of my identity document or birth certificate.
- ☐ 3. Original certificate of registration as a student.
- ☐ 4. Certificate of resumption of study issued by the University.

C. TO BE COMPLETED BY THE TRAINING INSTITUTION *(NO ALTERATIONS TO THIS DOCUMENT WILL BE ACCEPTED)*

Certificate of having commenced study as a student, issued by: .....

indicating that he/she enrolled on ..... (day) ..... (month) ..... (year)

in the (first, second, etc.) ..... year of study.

I consider him/her to be a competent and fit person to practice as a

ORIGINAL OFFICIAL DATE STAMP OF INSTITUTION

SIGNATURE: REGISTRAR ACADEMIC/HEAD OF DEPARTMENT **DATE**

*** Please complete for statistical purposes.**

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

Registration Officer: ..... Signature: ..... Date: .....

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.

Updated/LS/06-2014