****

PLEASE PRINT:

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| --- | --- |
| **APPLICATION FOR REGISTRATION AS** | **Form 12** |
|  |  |
|  | MEDICAL PRACTITIONER |  | SPECIALIST |  | INTERN |  | DENTIST |
|  |
| CATEGORY |  | Public Service |  | Supernum Reg |  | ……………………………………………………………. |

1. Title (Prof, Dr): …………... Surname:

2. Maiden Name (if applicable):

3. First name(s):

4. Date of birth: ……………………………….... Birth Place:

5. Postal address:

Tel. (Work): …………………………………………….. (Home):

Cell: ……………………………………………………………………. Fax: ……………………………………………………...

E-mail Address: …………………………………………………….……………………..

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*Marital Status: | Divorced |  | Married |  | Single |  | \*Gender: | Male |  | Female |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*Race | African |  | Asian |  | Coloured |  | White |  | \*Country of origin: | …………………………………………… |

 \* For statistical purposes only – Information required by the National Department of Health.

6. **Qualifications:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Degree** | **University or Institution where degree/qualification** **was obtained** | **From** | **To** |
| **Month** | **Year** | **Month** | **Year** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| 7. **Internship** (Full details to be provided and documentary evidence attached) |
| **Clinical Domains** | **Name of Institution** | **From** | **To** |
| **Month** | **Year** | **Month** | **Year** |
| General Medicine |  |  |  |  |  |
| General Surgery |  |  |  |  |  |
| Obstetrics and Gynaecology |  |  |  |  |  |
| Paediatrics |  |  |  |  |  |
| Family Medicine |  |  |  |  |  |
| Mental Health |  |  |  |  |  |
| Orthopaedics |  |  |  |  |  |
| Orthopaedic Trauma |  |  |  |  |  |
| Primary Health Care |  |  |  |  |  |
| Anaesthetics |  |  |  |  |  |
| Number of general anaesthetics personally administered |  |  |
| Other: |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |
| 8. **Professional Experience** (in chronological order) |
| **Name of Institution** | **Nature of****appointment held** | **From** | **To** |
| **Month** | **Year** | **Month** | **Year** |
|  |  |  |  |  |  |
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**9.** **DECLARATION BY APPLICANT APPLYING FOR REGISTRATION IN TERMS OF THE HEALTH PROFESSIONS ACT, 1974**

I, …………………………………………………………………………………………………..hereby declare under oath as follows:

a. I am the person referred to in the accompanying certificate(s) of qualification(s) which I submit in support of my application to be registered as a Medical Practitioner/Dentist in the Republic of South Africa.

b. The said qualification(s) was/were granted to me after examination and is/are my own lawful property, and entitle me as far as professional qualifications are concerned, to practise as a Medical Practitioner/Dentist in the country of its/their origin, namely -

c. The course of study in professional subjects which I underwent, covered a period of ………………….. academic years. The last …………….. academic years of professional study for admission to the examination for the qualification(s) in respect of which I apply for registration, were taken at ………………………………………………….…………. (insert name of University or Medical/Dental School).

d. I have never been convicted in any country of any offence against the law or been debarred from practice by reason of misconduct and, to the best of my knowledge and belief, no proceedings involving or likely to involve a charge of any such nature are pending against me in any country at present\*.

e. I further accept that my application may be delayed should I fail to submit all the required documentation.

**Signature** ………………………………………………..………

SWORN before me at ………………………………………………………… this …………………………………….….day of

…………………………………………………………. 200…………

**Signature:** …………………………………………………………….

**Justice of the Peace or Commissioner of Oaths**

I, the undersigned\*\*

of hereby declare under oath:

I personally know

whose signature appears above. To the best of my knowledge and belief, the statements in his/her declaration are true.

I consider him/her to be a fit and proper person to be registered as a Medical Practitioner/Dentist.

**Signature**  ………………………………………Profession or calling ……………………………………………

SWORN before me at …………………..……….this.............................day of

………………………………………………………….. 200 ……

**Signature** …………………………………………………………..

Justice of the Peace or Commissioner of Oaths

District of

I, the undersigned\*\*

of hereby declare under oath:

I personally know

whose signature appears above. To the best of my knowledge and belief the statements in his/her declaration are true.

I consider him/her to be a fit and proper person to be registered as a Medical Practitioner/Dentist.

**Signature**

Profession or calling

SWORN before me at this………………………………..day of

………………………………………………………… 200………

**Signature:** …………………………………………………………

Justice of the Peace or Commissioner of Oaths

District of

\* If the applicant is unable to make the declaration above, the Council, in order to consider the application, will require full particulars of the reasons for his or her inability.

\*\* The signatories should preferably be Medical Practitioners or Dentists.

9. Any other relevant facts which the applicant wishes to bring to the attention of the Board:

|  |
| --- |
| **FOR OFFICIAL USE ONLY** |
| **Documents received** | **Yes** | **Date Received** |
| **Form 12** |  |  |
| Copy of degree certificate - Notarised |  |  |
| Personal Curriculum Vitae |  |  |
| Sworn Translation in English - Notarised |  |  |
| Proof of Intern Training in Medicine Form 10A (Practical/Clinical Training) |  |  |
| Verification of credentials Report by the ECFMG |  |  |
| Certificate of Status |  |  |
| Proof of citizenship, Passport or Identity Document |  |  |
| Letter issued by the Department of Health re Employment |  |  |
| Examination Fee |  |  |
| Registration Fee |  |  |
| IELTS Certificate  |  |  |

**COMMENT**:

**Checklist of Documents in support of the HPCSA registration application:**

|  |  |
| --- | --- |
|  | Completed HPCSA Form 12 |
|  | **NOTARIZED** copy of Basic and all subsequent Medical / Dental qualification certificates |
|  | **NOTARIZED** copy of Medical Licence or Registration certificate |
|  | **NOTARIZED** copy of Passport |
|  | Proof of completed Internship training |
|  | FWMP Endorsement letter (will be added by the University) |
|  | Letter in support of the application from the Dean of the Faculty of Health Sciences (Will be added by the University) |
|  | Attached credit card authorization form - Registration and pro rata annual registration fees payable to the Health Professions Council of South Africa (please consult their website for the registration fee rates) |

**Please note: Faxed or scanned copies are not accepted by the HPCSA, originals or copies notarized by a notary public are required**

**Queries about registration with the HPCSA can be addressed to Matsheko Mokau** **MatshekoM@hpcsa.co.za** **- In addition, comprehensive information is available on the HPCSA website at** [**www.hpcsa.co.za**](http://www.hpcsa.co.za)**.**

**Credit Card Authorization**

*I hereby authorize the Health Professions Council of South Africa to debit my credit card account as follows:*

Card type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Cardholder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit card amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized signatory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For attention of: **Matsheko Mokau**