Health Professionals Council (Seychelles)

TITLE: Request for Change Form		
Form Number: HPC-F012-SOP-005	**Revision Number**: 0	Page **1** of **1**
Effective Date: Aug 2019	**Review Date**: Aug 2020	**Document Level**: 4

Registrant Number: ……. Date of Request: ……. /……./……

NIN Number/ Passport Number (delete non-applicable): ……
(*Attach a copy of identification document as selected above*)

Declaration:

I, …… hereby authorize the Council to change my personal/professional details as stated below. I confirm that these changes are true and correct to the best of my knowledge. I understand that false disclosure can lead to disciplinary action being taken against me.

**Tick as appropriate*:

	*	**Original** Information provided	**New** Information provided
Change of Surname (*provide a copy of national identification card or equivalent*)			
Change in Residential address (*attach proof of address, e.g. recent bill or letter from a bank*)			
Change in Correspondence address			
Change of employer			
Change of work address			

Signed by AHP: …… Date: …./…./…….