HEALTH PROFESSIONALS COUNCIL (HPC)

APPLICATION FOR RENEWAL OF REGISTRATION

Please complete and return the ORIGINAL FORM to:

The Registrar
Health Professionals Council
Room B2, Block B, Residence L'Hermitage, Mont Fleuri
Tel: 4303745 Mobile: 2606128
Email: registrarhpc@health.gov.sc / registrar@hpcseychelles.org

HPC/QR/002

A. PERSONAL DETAILS (*Tick as appropriate*)

Mr.	Mrs.	Ms.	Dr.

Gender: Male ☐ Female ☐ Registration Number ☐

Surname: ______________________________

Maiden Name (*if applicable*): ______________________________

Name(s): ______________________________

Have you had any change of name/surname since your last registration? Yes ☐ No ☐

If Yes, please indicate full name previously registered with: ______________________________

(*Please attach proof of name change*)

National Identity Number: ☐☐☐ ☐☐☐☐ ☐ ☐ ☐☐

Marital Status: Divorced ☐ Married ☐ Single ☐ Others ☐

Residential Address: ______________________________ Postal Address: ______________________________

Tel (Home): ______________ Tel (Work): ______________

Mobile: ______________ Email: ______________

Checklist: **Proof of name change attached (*if applicable*)** ☐

Office use only
Receipt*: ______________

B. WORK DETAILS IN SEYCHELLES

Practicing ☐ **Non-Practicing** ☐ *If Non-practicing, how long since you last practiced the profession?* ☐

Profession(s) renewing registration for: ______________________________

Place of Work: ______________________________
(*if practicing*)

Workplace address: ______________________________
(*if practicing*)

Supervisor Full Name: ______________________________ Supervisor Tel. No: ______________

Have you attended any Continuous Professional Development (CPD) workshop/seminar/training/session during the past two years? If Yes, state the number of Hours & attach relevant proof

YES ☐ NO ☐ Number of Hours: ________ Sign: ______________ Date: ______________

Checklist: **Proof of CPD attached** ☐

C. CERTIFICATE OF CHARACTER

(given by either your current supervisor, a Judge, a Magistrate, a Senior Government Officer, a Legal Practitioner, a Medical Practitioner or a Bank Manager - **OFFICIALLY STAMPED**)

I (*Full Name*) ______________________________ of (*work place*) ______________________________, working as ______________________________ certify that the information given on this form is true and correct to the best of my knowledge.

Sign: ______________ Date: ______________