ALLIED HEALTH PRACTITIONERS COUNCIL OF ZIMBABWE

20 Worcester Road,

Eastlea, Harare

P.O. Box A14 Avondale, Harare

Tel: +263 04-303027, +263 771 056 413

E-mail: [registrations@ahpcz.co.zw](mailto:registrations@ahpcz.co.zw)

Website: [www.ahpcz.co.zw](http://www.ahpcz.co.zw)

# APPLICATION FOR TEMPORARY REGISTRATION

## Incomplete applications will be subject to delay in processing

### DOCUMENTS WHICH MUST BE SUBMITTED WITH THIS FORM

**All applicants**

1. Certified copy of national identity document
2. Invitation letter/Supporting documents from the host organization in Zimbabwe providing time when practitioner is expected to be practicing
3. One recent passport-size photograph.
4. Valid Practising Certificate from home country health Council
5. Certificate of Goodstanding from home country health Council.

**NOTE:**

1. Documents which are in a language other than English must be translated into English by a recognised interpreter and properly authenticated.
2. *The Council is empowered to require an applicant to with specific requirements – eg employment under supervision, as a condition of registration.*
3. *Applicants must comply with the Zimbabwe immigration laws.*

***Any person who practices his profession in Zimbabwe whilst not registered and is not in possession of a current practicing Certificate is liable to prosecution.***

**A fee of $……… must be enclosed with this application.**

RECEIVED (amount) …………….. DATE………………. RECEIPT NO…………………..

**I hereby make application for temporary registration as a/an…** *(Please Tick One)*

|  |  |  |  |
| --- | --- | --- | --- |
| Ambulance Technician |  | Hospital Equipment Technician |  |
| Clinical Social Worker |  | Medical Physicist |  |
| Counsellor |  | Nutritionist |  |
| Dietician |  | Operating Theatre Technician |  |
| E.C.G. Technician |  | Paramedic |  |
| E.E.G Technician |  | Psychologist |  |
| Emergency Medical Technician |  | Radiographer |  |
| Health Promotion Officer |  | Ultrasonographer |  |
| Health Information Management Practitioner |  | X-ray Operator |  |
|  |  |  |  |

**1. PERSONAL DATA**

|  |  |
| --- | --- |
| TITLE: | MR ( ) MRS ( ) MISS ( ) MS ( ) DR ( ) PROF ( ) |
| GENDER | MALE ( ) FEMALE ( ) |
| SURNAME: |  |
| FIRST NAMES: |  |
| PREVIOUS NAMES: (where applicable) |  |
| DATE OF BIRTH: |  |
| E-MAIL ADDRESS |  |
| PLACE OF BIRTH – COUNTRY |  |
| NATIONALITY |  |
| MARITAL STATUS: | MARRIED ( ) SINGLE ( ) OTHER (State) |
| PERMANENT HOME ADDRESS: |  |
| CONTACT ADDRESS: |  |
| PHONE NUMBER: |  |
| PASSPORT OR ID NUMBER |  |

1. **PROFESSIONAL QUALIFICATIONS**

|  |  |  |
| --- | --- | --- |
| QUALIFICATIONS | NAME OF  TRAINING INSTITUTION | DATE  AWARDED |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **PROFESSIONAL REGISTRATION DETAILS**

|  |  |  |
| --- | --- | --- |
| **PROFESSIONAL BOARD** | **PROFESSION** | **REGISTRATION NO.** |
|  |  |  |
|  |  |  |

1. **ACTIVITY/WORKSHOP/EVENT TO BE ATTENDED**

|  |  |  |
| --- | --- | --- |
| **ACTIVITY TITLE** | **DATES** | **LOCATION/ADDRESS** |
|  |  |  |
|  |  |  |

###### SOLEMN DECLARATION

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Full Name)

A, (Quote Profession)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

do hereby solemnly and sincerely declare as follows:

1. THAT –
2. All the information provided above is true
3. I have never been debarred from practice on the grounds of professional misconduct;
4. my name has never been removed from any register of members of my profession kept in accordance with the laws of any country in which I have practised my professions;
5. no inquiry is pending which may result in –
6. my being debarred from practice on the grounds of professional misconduct; or
7. the removal of my name from any register referred to in sub-paragraph (b).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Signature of Education Committee Chairman/Registrar \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Application Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Application Disapproved

NOTE: This form is required to be completed and signed by one of the following persons –

The Registrar or Chairman of the Allied Health Council; or a member of the Education Committee as the attesting officer.