Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reg No. \_\_\_\_\_\_\_\_\_\_\_

Reg Date:\_\_\_\_\_\_\_\_\_\_\_

ALLIED HEALTH PRACTITIONERS COUNCIL OF ZIMBABWE

20 Worcester Road

Eastlea, Harare

P.O. Box A14

Avondale, Harare

Phone: +263 4 303027, Cell: +263 771 056 413

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

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

# APPLICATION FOR REGISTRATION

## Incomplete applications will be subject to delay in processing

### DOCUMENTS WHICH MUST BE SUBMITTED WITH THIS FORM

1. Certificate of Good Standing issued by the appropriate Council/Authority where you are currently practicing (issued within the last three months).
2. Certified copies of Degrees & Transcripts, Diplomas, Certificates, A’level/O’level.
3. Certificate of completion of internship/ a file of practical internship program
4. Two recent testimonials from professional supervisors/school of training (relative to the last six months), (use reference check form).
5. Syllabus of the intended internship program
6. Letter of commitment from internship supervisor/ job description (where appropriate)
7. Record of student practical training.
8. One recent passport-size photograph.
9. Certified Copy of national ID document.
10. Any other supporting documents.
11. Certified copy of Drivers Licence

12. Affidavit of work experience (if you have more than 3 months after qualification)

13. Confirmation letter of employment from Employer (for those who are employed)

14. Letter from applicant on payment for internship supervision.

15. Valid Work Permit (For Foreigners)

16. Course Content/Syllabus for foreign qualifications which have never been registered by AHPCZ

17. Copies of AHPCZ Student Registration and Practicing Certificates

**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/ her profession in Zimbabwe whilst not registered and is not in possession of a current practicing Certificate is liable to prosecution.***

**Board Examination Fee**

Received (amount) …………….. Date ………………. Receipt No. ……………………………

**Registration Fee**

Received (amount) …………….. Date ………………. Receipt No. ……………………………

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

|  |  |  |  |
| --- | --- | --- | --- |
| Ambulance Technician |  | Clinical Social Worker |  |
| Counsellor |  | Dietician |  |
| E.C.G. Technicians |  | E.E.G Technician |  |
| Emergency Medical Technician |  | Health Education Promotion Practitioner |  |
| Hospital Equipment Technician |  | Hospital Food Service Supervisor |  |
| Medical Physicist |  | Natural Therapist |  |
| Nutritionist |  | Operating Theatre Technician |  |
| Paramedic |  | Psychologist |  |
| Radiographer |  | X-Ray Operator |  |

**1. PERSONAL DATA**

|  |  |
| --- | --- |
| TITLE: | ........................... (Mr, Mrs, Miss, Dr, Prof) |
| GENDER | MALE / FEMALE |
| SURNAME: |  |
| FIRST NAMES: |  |
| PREVIOUS NAMES: (where applicable) |  |
| DATE OF BIRTH: | Day/Month/Year |
| E-MAIL ADDRESS |  |
| PLACE OF BIRTH – COUNTRY |  |
| NATIONALITY |  |
| MARITAL STATUS: | MARRIED / SINGLE / OTHER (STATE) |
| PERMANENT HOME ADDRESS: |  |
| CONTACT ADDRESS: |  |
| PHONE NUMBER: |  |
| ID REGISTRATION NUMBER |  |

1. **PROFESSIONAL QUALIFICATIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| QUALIFICATIONS | NAME OF  INSTITUTE | FROM | TO | AWARDED BY | DATE  AWARDED |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. **DETAILS OF TRAINING** (where applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| NAME AND PLACE | FROM | TO | DISCIPLINE |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **DETAILS OF PRESENT EMPLOYER**

|  |  |
| --- | --- |
| NAME OF EMPLOYER |  |
| ADDRESS AND CONTACTS |  |
| JOB TITLE |  |
| BRIEF JOB DESCRIPTION |  |
| PERIOD / DATE EMPLOYED | FROM |

**5. PREVIOUS EXPERIENCE/EMPLOYMENT**

Please list all RELEVANT employment experience in reverse chronological order. You are welcome to provide greater details in an attachment to this form.

5.1 DATES FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JOB TITLE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BRIEF JOB DESCRIPTION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

5.2 DATES FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JOB TITLE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BRIEF JOB DESCRIPTION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

5.3 DATES FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JOB TITLE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BRIEF JOB DESCRIPTION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**6. CAREER OBJECTIVE** (Including aims of obtaining registration and proposed field of practice)

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

**7. ANY OTHER RELEVANT INFORMATION**

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

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

###### SOLEMN DECLARATION

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Full Names)

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

of (Residential Address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Business Address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

do hereby solemnly and sincerely declare as follows:

1. THAT I am the person whose name appears on the certificates of the degree, diploma or other certificate on which I rely as a qualification for registration,

being Certificate No (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dated\_\_\_\_\_\_\_\_\_\_\_\_\_\

which was issued to me by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_after being duly

examined.

1. THAT –
2. I have never been debarred from practice on the grounds of professional misconduct;
3. 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;
4. no inquiry is pending which may result in –
5. my being debarred from practice on the grounds of professional misconduct; or
6. the removal of my name from any register referred to in sub-paragraph (b).
7. THAT the universities, medical schools or training schools at which and the periods during which I received my training are as follows:-

Name of Institution Period of Training

From … To

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

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

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

1. THAT I reside or intend if registration is granted to reside within Zimbabwe.

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

**Applicant’s Signature Date**

**For AHPCZ Office**

**Application Approved ( ) Application Disapproved ( )**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.**