ALLIED HEALTH PRACTITIONERS COUNCIL OF ZIMBABWE
20 Worcester Drive
Eastlea, Harare
P.O. Box A14 Avondale, Harare,
Tel: +263 04-303027, +263 771 056 413
E-mail: registrations@ahpcz.co.zw
Website: www.ahpcz.co.zw

REGISTRATION OF SERVICES

APPLICATION FOR THE REGISTRATION OF SERVICES

Registration Fee $…… Date Receipted…… Receipt Number……

Tick where applicable:

a)	New Registration	……....
b)	Change of Practitioner in Charge	……
c)	Change of Medical Director	……
d)	Change of Premises	……
e)	Addition of Ambulances	……
f)	Change of Level of care/training	…….
g)	Accreditation of Training School	…….
h)	Change of Name	…….

1. **TRADE NAME OF SERVICE**

   _____

2. **SERVICE TO BE OFFERED/ PROPOSED LEVEL OF CARE /TRAINING OFFERED**

   _____

3. **PHYSICAL ADDRESS**

   _____

   _____

4. **POSTAL ADDRESS**

   _____

   _____

5. **TELEPHONE NUMBER**_____

6. **EMAIL ADDRESS**_____

7. **BOARD OF DIRECTORS**

   1) (name and address)----------
   2) (name and address)----------
   3) (name and address(----------

8. **PRACTITIONER IN CHARGE**

NAME:----------

ADDRESS----------

E-MAIL ADDRESS----------

CELL NUMBER----------

QUALIFICATION----------

REGISTRATION NUMBER----------

OTHER PRACTICES----------

---

9. **MEDICAL DIRECTOR**

NAME:----------

ADDRESS----------

CELL NUMBER----------

EMAIL ADDRESS----------

QUALIFICATION----------

REGISTRATION NUMBER----------

10. **PERSONNEL**

NAME	QUALIFICATION	REG. NUMBER
----------	----------	----------
----------	----------	----------
----------	----------	----------
----------	----------	----------
----------	----------	----------

10. DETAILS OF OWNER OF PREMISES:

FULL NAMES:_____

ADDRESS:_____

I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEVE THAT THE FOREGOING PARTICULARS ARE TRUE AND REQUEST REGISTRATION OF THE AFOREMENTIONED SERVICE

DATE:_____ FULL NAMES:_____

DESIGNATION:_____ **SIGNATURE**_____