

FORM 2

APPLICATION FOR REGISTRATION

THE HEALTH PRACTITIONERS ORDINANCE

(Section 6(2))

APPLICATION FOR REGISTRATION

Dr/Mr/Mrs/Miss

Last Name First Name Other names Maiden name

Nationality Date of Birth

Place of Birth

Present Address

Permanent Address.....

Phone Contact..... Fax Email

Profession

Professional Education:

Name and Location Dates Qualifications (degree etc.)

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.....

Professional Experience:

Name and Location Dates Additional Details

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.....

Professional References:

Name Title Address

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Have you ever been arrested or convicted of a crime? If yes, state nature of charge, date and disposition:

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.....

Have you ever been the subject of professional disciplinary action? If yes, state nature of inquiry, date and disposition:

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I understand the giving of false or misleading information will result in cancellation of registration and forfeiture of the fee tendered. I grant the Board permission to investigate my background and contact my references. I have read and understand the Health Practitioners Ordinance.

Date: Applicant's signature

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Applicant, please enter the amount of the fee tendered, this date, with the application form \$.....

(Note: If further space is required, please use additional pages.)

FOR OFFICIAL USE ONLY

Date of application and fee received by

Date fee paid into Treasury by

Investigator's report

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Date application presented to Board by

Date of Board's decision on application

Disposition of application

Additional Notes

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This application is the property of the Government of the Turks and Caicos Islands and will be kept in the confidential custody of the Chairman, Health Practitioners Board.