

**MEDICAL REHABILITATION COUNCIL OF ZIMBABWE**

14 Betram Road P.O.Box A667

Milton Park AVONDALE

HARARE HARARE

ZIMBABWE

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**SPECIALIST REGISTER APPLICATION FORM**

**CATEGORY OF SPECIALITY APPLIED FOR**

…………………………………………………………………………………………………………………………………………

MANDATORY DOCUMENTS TO BE SUBMITTED WITH THIS FORM

CHECKLIST (Please tick)

Applicant Office use

|  |  |  |
| --- | --- | --- |
| 1. Notarised copies of Degrees , Diplomas, Certificates |  |  |
| 1. Certified copy of Identity Card |  |  |
| 1. Two passport-size photographs |  |  |

***NOTE:***

1. *It is an offence to practise any medical profession in Zimbabwe without registration or without a current practicing Certificate according to the Health Professions Act (Chapter 27:19).*
2. *Incomplete applications may be subject to delay in processing.*
3. **PROFESSIONAL REGISTRATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PRIMARY PROFESSIONAL QUALIFICATION | REGISTRATION DATE | CURRENT LICENSE NUMBER | DATE OF ISSUE | EXPIRY DATE |
|  |  |  |  |  |
|  |  |  |  |  |

1. **PERSONAL DATA**

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|  |  |
| --- | --- |
| SURNAME |  |
| FIRST NAME (s) |  |
| PREVIOUS NAMES  (where applicable) |  |
| DATE OF BIRTH |  |
| TITLE |  |
| SEX |  |
| PLACE OF BIRTH: TOWN |  |
| COUNTRY |  |
| NATIONALITY |  |
| PASSPORT: Yes/No. If yes please give number and expiry date |  |
| CULTURAL COMPETENCE |  |
| RELIGION |  |
| WORK PERMIT: Yes/No. If yes please give details |  |
| PERMANENT HOME ADDRESS |  |
| CONTACT ADDRESS |  |
| PHONE NUMBER |  |
| EMAIL ADDRESS |  |

1. **PRIMARY PROFESSION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| QUALIFICATIONS  *(Dip/Cert/Degree/* | NAME OF TRAINING INSTITUTE | DURATION | | AWARDED BY | DATE AWARDED |
| FROM | TO |
|  |  |  | |  |  |
| ADDITIONAL INFORMATION  *(Dip/Cert/Degree* |  |  | |  |  |

**5.** **MEMBERSHIP WITH PROFESSIONAL ASSOCIATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF PROFESSIONAL ASSOCIATION | COUNTRY | MEMBERSHIP NUMBER ( if applicable) | MEMBERSHIP EXPIRY DATE( if applicable) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **RELEVANT WORK HISTORY (where applicable)**

Please list all work history starting with the most current position at the top. You may print and attach more pages if necessary.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| FROM  (DD/MM/YY) | *TO :*  (DD/MM/YY) | EMPLOYER’S NAME AND ADDRESS | JOB TITLE | BRIEF JOB DESCRIPTION |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. CPD ( List your most immediate CPD participation in the last 5 years in the following table)

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Event and duration | Presenter | Method of evaluation |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Note: Attach evidence (e.g. certificates)

If no CPD activity give reasons: …………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

1. **Statutory Declaration**

(This *must be made before someone entitled to take statutory declaration e.g. Solicitor, Commissioner of Oaths, who must provide their full name, physical address and contact telephone and email):*

I hereby certify that the information I have given above is correct. With this application, I confirm that I am fit and qualified to practice as a.........................………………………………………………I understand that a misrepresentation of information will result in my application being disqualified.

Name of applicant: .............................................................................................

Signature of applicant: .................................................................................

Declared at (location).......................................................................

This: ....................................... day of: ........................................... year..............................................

Before me (official authorised to take a statutory declaration):

Full name of official: ..........................................................................................

Signature of official: ..............................................................

(Designation, full address, phone number and official seal):

DATE: ............................................................................................. SIGNATURE............................

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**FOR OFFICIAL USE ONLY**

**APPROVED**

|  |  |
| --- | --- |
| YES | NO. |
|  |  |

IF YES:

DATE OF REGISTRATION.............................................................................................................

REGISTRATION NUMBER..............................................................................................................

SPECIALITY...................................................................................................................................

IF NO:

REASON..........................................................................................................................................

DATE...................................................................................SIGNATURE.........................................

**NOTE:**

1. **PAYMENT**

A ***NON-REFUNDABLE***APPLICATION FEE OF RTGS***1469.00*** FOR ZIMBABWE CITIZENS AND US$150.00 FOR NON ZIMBABWE CITIZENS IS NEEDED TO PROCESS THIS APPLICATION.

**APPLICATION FEES CAN BE DEPOSITED INTO THE MEDICAL REHABILITATION COUNCIL’S BANK ACCOUNT**

**BANK DETAILS**

BANK :CABS

BRANCH : FOURTH STREET

ACCOUNT NAME : MEDICAL REHABILITATION PRACTITIONERS COUNCIL OF ZIMBABWE

ACCOUNT NUMBER : 1004389094