

The Allied Health Professionals Council of Mauritius
 Ministry of Health and Wellness, 3rd floor, Emmanuel Anquetil Building
 Sir Seewoosagur Ramgoolam St, Port-Louis.
 email : ahpcregistrar2018@gmail.com

FOR OFFICE USE ONLY

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APPLICATION FOR REGISTRATION AS AN ALLIED HEALTH PROFESSIONAL

PLEASE PRINT CLEARLY and COMPLETE IN BLACK INK

SECTION A : REGISTRATION REQUESTED

Please mark the relevant professional category. Only one profession per application form.

Tick the box :

Tick the box :

Cluster 1	
Occupational Therapist	<input type="checkbox"/>
Orthopedic Technician	<input type="checkbox"/>
Physiotherapist	<input type="checkbox"/>
Podiatrist	<input type="checkbox"/>
Sport Therapist	<input type="checkbox"/>
Cluster 2	
Audiologist	<input type="checkbox"/>
Speech and Language Therapist	<input type="checkbox"/>
Cluster 3	
Dietitian	<input type="checkbox"/>
Nutritionist	<input type="checkbox"/>
Cluster 4	
Counsellor	<input type="checkbox"/>

Psychologist/Clinical Psychologist	<input type="checkbox"/>
Psychotherapist	<input type="checkbox"/>
Psychomotortherapist	<input type="checkbox"/>
Cluster 5	
Chiropractor	<input type="checkbox"/>
General Chiropractor	<input type="checkbox"/>
Chiropractic Specialist	<input type="checkbox"/>
Osteopath	<input type="checkbox"/>
Cluster 6	
Clinical Scientist	<input type="checkbox"/>
Medical Imaging Technologist	<input type="checkbox"/>
Medical Laboratory Technologist	<input type="checkbox"/>

SECTION B : PERSONAL DETAILS

Title : Prof/ Dr/ Mr/ Mrs/Ms (Please indicate)

Surname :

Full first name(s) :

Date of Birth : Gender :

Nationality : NIC number (Mauritian Citizen)

Passport number (Expatriate)

If you are not a Mauritian Citizen :

- Do you hold a residence permit granted by the Passport & Immigration Office (Please attach proof)
or
- Do you hold a Working Permit or an Occupational Permit and date of last renewal if any (Please attach proof) ?

Home address :

Telephone (home) :

Work address :

District :

Telephone (work) : mobile :

E-mail :

SECTION C : EDUCATION AND TRAINING FOR REGISTRATION

Secondary qualifications : SC /YearHSC (or Baccalauréat)/Year

Professional qualification as per first schedule AHPC act 2017					
Full title of professional qualification and year attained	Name of institution	Year course started	Year course completed	Course duration	Full time/ Part time

Technical /Clinical experience obtained during professional qualification				
Name of institution	Date of start of training	Date training completed	Duration of training	Full time/part time

Technical /Clinical experience after obtaining professional qualification				
Name of institution	Date of start of training	Date training completed	Duration of training	Full time/part time

Postgraduate qualification(s)						
Full title of postgraduate qualification and year attained	Area of specialization (if applicable)	Name of institution	Date course started	Date course completed	Course duration	Full time /part time

SECTION D: PREVIOUS REGISTRATION WITH ANY FOREIGN COUNCIL(S)

Name of Council	Period of registration	Type of registration	Country

SECTION E: CURRENT EMPLOYMENT

Name of employer or self employed:	
Address of employer:	
Address of place of work:	
Job Title/Appointment of applicant:	
Date of appointment:	
Department:	
Status of employment Full time Part time	Main nature of work: <input type="radio"/> Technical <input type="radio"/> Technical and scientific <input type="radio"/> Providing clinical service <input type="radio"/> Research <input type="radio"/> Management/Administration <input type="radio"/> Others (specify)

SECTION F: EMPLOYMENT HISTORY

Date of joining	Date of leaving	Grade /Title of post held	Name of employer and Department	Country	Status F/T P/T

SECTION G : DECLARATIONS

- I declare that I have read, understood and will comply with the AHPC 'S Code of Practice
- I confirm that I have read the guidance note for applicants which accompanies the application form and understand that the AHPC may process my personal data.
- I agree to pay the processing, registration and annual practising licence fees.
- I consent to the AHPC contacting any person to obtain further information about my application or to verify the information that I have provided and agree that any person who is contacted may provide the AHPC with any information about me which that person holds.
- I am of good character and have not been convicted of any crime involving fraud or other dishonesty.
- I have not been struck off the list of persons entitled to practise my profession in any country
- I am not incapacitated by reason of any physical or mental health.
- I confirm that the information I have provided in this application is correct and that fraudulently procuring an entry in the AHPC Register is a criminal offence « under section 38 of the AHPC Act 2017 »

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Date

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Signature