Form CPD 2A	APPLICATION FOR APPROVAL OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD) ACTIVITIES

Please complete and submit for a recommendation to an Accreditor
NOTE: Detailed activity programme, content of each presentation (general and ethical) and presenter CV's are required to be submitted with this application

Name of Providing Organisation and/or Name of Provider/Name of Individual (Including HPCSA Registration Number)			
Postal Address of Providing Organisation and/or Provider and/or Individual			
VAT Number of Providing Organization/Provider (if applicable)			
Target audience			
Related target audience			
Contact Person (Organisation/Provider/Individual)			
Telephone Number (Including Area Code) (Organisation/Provider/Individual)			
Fax Number (Including Area Code) (Organisation/Provider/Individual)			
e-Mail Address (Organisation/Provider/Individual)			
Activity Title			
Date(s) of Activity/Programme			
Presenter/s name/s and registration number/s with HPCSA or other Council/Organisation.			
Indicate the potential of the activity to enhance professional performance			
Venue (Full physical address) of proposed activity (If applicable)			
Level of Proposed CPD Activity			
Registration Fee involved for participants	-		
Duration of the learning activity (hours)			
Suggested CEU's (General)	**Level 1**	**Level 2**	**Level 3**

Suggested CEU's in Medical Ethics, Human Rights and Legal Issues pertaining to health sciences	**Level 1**	**Level 2**	**Level 3**
Suggested number of CEU's (Indicate Maximum Points In each Level)	**Level 1**	**Level 2**	**Level 3**
Specify intended method of evaluation (i.e. Questionnaire			
Specify the intended mechanism of monitoring attendance (per hour or per session for the duration of the activity)			
Have you applied to another accreditor to have this activity approved. If yes, to whom and what was the outcome	Name of Accreditor: ……		

Organisations/Providers only:

With the submission of this application, I herewith undertake to monitor the attendance per session, evaluate the presentations as specified and to inform the accreditors accordingly. I recognize the authority of the Board/Accreditors to cancel the accreditation on non-compliance to the criteria.

NOTE: Payment terms is 30 days from date of invoice

Signature: ORGANISATION/PROVIDER/INDIVIDUAL **Date:……**

Designation:

FOR THE OFFICIAL USE OF THE ACCREDITOR

This is to certify that ……(name of Accreditor) -

has agreed to the proposed CPD points as follows:

Level 1	Level 2	Level 3	Ethics/Human Rights/Legal Matters

Specify ethical/human rights/legal matters relating to health sciences

TOTAL:

Specify the reasons why the above-named Accreditor does not agree to accreditation:
……
……

_____

SIGNATURE ON BEHALF OF DESIGNATED CPD ACCREDITOR **DATE: ……**

NAME AND DESIGNATION:	

CERTIFICATE OF CPD ATTENDANCE *FORM CPD 3*

ACCREDITATION NUMBER AS PER THE GUIDELINES

TOPIC OF THE ACTIVITY

LEVEL OF THE ACTIVITY

NAME AND REGISTRATION NUMBER OF PRACTITIONER

DATE OF ACTIVITY

NUMBER OF CEU'S IN LEVEL(S)

Level 1	Level 2	Level 3

_____ _____

SIGNATURE PROVIDER **DATE SIGNED**