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

Please complete and submit for a recommendation to a Profession-specific Accreditor
NOTE: The programme for the Activity and the Presenter's CV must be submitted with this application preceding the activity. **No retrospective approval will be made.**

Name of Providing Organisation/Provider (Including HPCSA Registration Number)		
Postal Address of Providing Organisation/Provider		
VAT Number of Providing Organization/Provider (if applicable)		
Target audience		
Contact Person (Providing Organisation/Provider)		
Telephone Number (Including Area Code) (Providing Organisation/Provider)		
Fax Number (Including Area Code) (Providing Organisation/Provider)		
e-Mail Address (Providing Organisation/Provider)		
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 (Required for reporting to HPCSA)		
Venue (Full physical address) of Activity (If applicable)		
	Postal code	
Level of Proposed CPD Activity		
Registration Fee involved for participants	-	
Duration of the learning activity (hours)		
Suggested CEU's (General)	**Level 1**	**Level 2**
Suggested CEU's in Medical Ethics, Human Rights and Legal	**Level 1**	**Level 2**

Issues pertaining to health sciences		
Suggested number of CEU's (Indicate Maximum Points In each Level)	**Level 1**	**Level 2**
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? Provide reason if the application was not approved.	Name of Accreditor: No:…… Outcome and reason…… ……	

Organisations/Providers:

With the submission of this application, I

a. submit my advertisement
b. declare that the activity would not be advertised without prior approval of the Accreditor
c. undertake to monitor the attendance for the duration of the activity
d. evaluate the presentations as specified and to inform the accreditors accordingly
e. recognize the authority of the Board/Accreditors to cancel the accreditation in the event of non-compliance with the criteria.

NOTE: Payment terms are 30 days from date of invoice

Signature:…… **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	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
(from Accreditor/Board)

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**	**Ethics, Human Rights and Health Law**

_____ _____

SIGNATURE PROVIDER **DATE SIGNED**