



FORM- I

Reg. No:

RWANDA ALLIED HEALTH PROFESSIONS COUNCIL APPLICATION FOR REGISTRATION (PROFESSIONAL)

NON-COMPLIANT APPLICATION WILL BE REJECTED

Please PRINT and return the ORIGINAL FORM to:

The Registrar. P.O. Box 6600 Kigali. 4 KG 632 Street. Rugando. Kimihurura

To be duly completed by the Applicant

A. PERSONAL IDENTIFICATION

Name:

Surname: Maiden Name:

Father's Names:

Mother's Names:

ID or Passport Number:

Place of issue:

Date of Birth:

Nationality:

Gender: Male

Female

Note: Please ensure all the prescribed requirements are attached to the completed FORM-I before submission to the Council (see I. Checklist)

B. CONTACT INFORMATION

Residential Address: Sector: District:

Street Name & Number: House/Plot Number:

Province/State: Country:

Postal address:.....Email:

Cell phone: Country of Origin:

Work Address (Name of the Institution): Contact Tel:

C. EDUCATION BACKGROUND

| Name of the institution | Country | Course/Programme | Qualification | Date (dd-mm-yyyy) | |
|-------------------------|---------|------------------|---------------|--------------------|----|
| | | | | From | To |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

D. ADDITIONAL TRAINING (From 3 Months)

| Name of the institution | Country | Course/Programme | Qualification | Date (dd-mm-yyyy) | |
|-------------------------|---------|------------------|---------------|--------------------|----|
| | | | | From | To |
| | | | | | |
| | | | | | |
| | | | | | |

E. WORK EXPERIENCE

1. Current Situation

| Name of the institution & Address | Position or Job Title | Key Responsibilities | Date (dd-mm-yyyy) | |
|-----------------------------------|-----------------------|----------------------|--------------------|----|
| | | | From | To |
| | | | | |

2. Previous Experience

| Name of the institution & Address | Position or Job Title | Key Responsibilities | Date (dd-mm-yyyy) | |
|-----------------------------------|-----------------------|----------------------|--------------------|----|
| | | | From | To |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

F. PREVIOUS REGISTRATION

| Name of the Regulatory Body | Country | Professional credential | Registration Number | Registration Status | Date (dd-mm-yyyy) | |
|-----------------------------|---------|-------------------------|---------------------|---------------------|--------------------|----|
| | | | | | From | To |
| | | | | | | |

G. PROFESSIONAL CATEGORY

- Anesthesia practitioner
- Audiology Practitioner
- Biomedical Laboratory Practitioner
- Biomedical Engineering Practitioner
- Clinical psychology Practitioner

- Nutrition Practitioner
- Ophthalmic Clinical Practitioner
- Optometry/ Optical Practitioner
- Orthotherapists
- Osteopathic Practitioner

- Clinical Officer (Clinical Medicine)
- Dental and Oral Health Practitioner
- Emergency Care Practitioner
- Environmental Health Practitioner
- Hearing Instrument Practitioner
- Medical Imaging Practitioner

- Physical Therapy Practitioner
- Prosthetics and Orthotics
- Public Health Officer
- Speech & Language Therapy
- Other (Specify):

H. DECLARATION

I authorize the Registrar to investigate and obtain from me, any person or any organization such information as may be required in relation to this application. I certify that the statements made by me in this application are true and complete. I am aware that misrepresentation or falsification may result in rejection of my application or withdrawal of registration.

Applicant's Names:

Signature:

Date:.....

I. CHECKLIST (Reception ONLY)

- Completed Application form
- All qualifications (Originals and notified copies)
- Academic Transcripts for the last Three years
- Proof of payment
- Copy of identity card or Valid Passport
- 2 Passport photos (3 x 3 cm)
- Police Clearance Certificate
- Employment Certificate (Where applicable)
- Equivalence Certificate issued by HEC (where applicable)
- Proof of Previous Registration (where applicable)
- Internship Certificate (where applicable)

| FOR OFFICE USE ONLY | | |
|-----------------------------------|--------------------------|---|
| Received on | Verified | Bank Details RAHPC |
| Amount | Date | 00262-0494227-39 Grand |
| Receipt No | Database record | Pension Plaza Bank of Kigali |
| Approved <input type="checkbox"/> | If rejected, reason: | |
| Rejected <input type="checkbox"/> | | |
| Registration Number: | | |

Signature:

Date: