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) 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
- ☐ Employement Certificate (Where applicate)
- ☐ 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** **00262-0494227-39** **Grand Pension Plaza Bank of Kigali**
Amount ……	Date ……	
Receipt No ……..	Database record ……	
Approved ☐ Rejected ☐	If rejected, reason:	
Registration Number: ……		

Signature: Date: