

The Commonwealth of The Bahamas
HEALTH PROFESSIONS COUNCIL

GUIDELINES FOR REGISTRATION

Attached is an application for registration to be completed and returned to The Health Professions Council along with notarized copies or the originals of the below listed documents.

Registrar Health Professions Council
Commonwealth of The Bahamas

Please tick appropriate box to ensure that all information (notarized copies or originals) is submitted

- Birth Certificate
- Police Certificate
- Health Certificate (to be completed by Physician)
- Passport size photograph
- Completed Posts Held form
- Completed authorization form (release of information)
- Certificate(s)
 - Msc.
 - B.A./Bsc.
 - Diploma
 - A.A.
 - Cert./Other
- Current Registration Certificate where applicable (notarized copy)
- Employment sponsorship letter (non-Bahamian only)
 - Private
 - Government
- Copy of current Work Permit
- Three (3) references (written)
 - Professional (2)
 - Character (1)

PLEASE NOTE:

- (a) **No application will be processed until the above requirements are received, along with an evaluation fee of Twenty-five dollars (\$25.00).**
- (b) A registration fee of _____ dollars (\$) is required to be paid on notification of approval of the application. (*Payment by certified cheque preferred*)
- (c) Legal action **will be** taken against any person who gains employment as a Health Professional, and is **not** registered to practice.

	\$ AMOUNT	RECEIPT No.
REGISTRATION FEE		

FOR OFFICIAL USE ONLY

APPLICATION FORM FOR REGISTRATION
(SECTION 12 - THE HEALTH PROFESSIONS ACT, 1998)

Profession: _____

1. Name in full: _____
(surname) (given names)

2. Date of Birth: _____ 3. Age: _____ 4. Sex: _____
(mm/dd/yy)

5. Place of Birth: _____ 6. Nationality: _____ 7. Marital Status: _____

8. Telephone: _____ (home) _____ (work)

9. Postal Address: _____ (home) _____ (work)

10. E-Mail: _____

11. Name of Contact Person: _____
(e.g. next of kin)

_____ Postal Address: _____ Telephone: _____

12. Professional Qualifications:
Name & Address _____
of Training Institution(s): _____
Date Qualifications obtained: _____
(enclose original diploma or certified/notarized copy) (originals will be returned)

13. List of additional and/or higher qualifications:
Name & Address _____
of Training Institution(s): _____
Date Qualifications Obtained: _____
(enclose original diploma or certified/notarized copy) (originals will be returned)

14. State type of practice you wish to pursue: _____
(professional classification)

15. Referees & Addresses: _____ { _____ {
_____ { _____ {
_____ { _____ {
_____ { _____ {
_____ { _____ {

16. Attach a recent photograph of yourself:



17. Have any proceedings ever been initiated against you by Allied Health Professions Licensing Authority?
(provide details):

18. For persons trained outside The Bahamas, please submit a notarized copy of current certificate of registration.

I hereby enclose the evaluation fee of twenty-five dollars (\$25.00).

I hereby forward my application and I promise, in the event of my being so registered (on payment of a fee of _____ dollars) to be bound by, and to conform in all respects to the Regulations in force.

I declare that I can clearly read, write, speak and understand the English Language, and that the information contained in this application is true and correct. Should any changes occur in the documentation presented with my application – I shall promptly notify the Council of the changes.

Signature of applicant: _____

Date: _____

**FORM TO BE COMPLETED AND RETURNED TO:
THE REGISTRAR**

Health Professions Council

P.O. Box N-7528

Nassau, The Bahamas

Office hours: Monday to Friday 9:00 a.m. – 5:00 p.m.

Telephone: (242) 326-7740 • (242) 326-0566

Telefax: (242) 326-0537

For Office Use Only	
REGISTRATION NUMBER	
REGISTRATION DATE	

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HEALTH PROFESSIONS COUNCIL

POSTS HELD

State all posts held since graduation, including type of experience gained.

DATES	POST HELD & EXPERIENCE GAINED	INSTITUTION (FULL ADDRESS)

TO APPLICANT: Please sign both authorization forms.

Name of Applicant: _____

Address: _____

Dear Sir/Madam,

I, _____, hereby request you to release any information on me, relative to my character and professional ability to the Health Professions Council, Commonwealth of The Bahamas.

Signature: _____ Date: _____

Social Security No./
National Insurance No: _____ Date of Birth: _____

TO APPLICANT: Please sign both authorization forms.

Name of Applicant: _____

Address: _____

Dear Sir/Madam,

I, _____, hereby request you to release any information on me, relative to my character and professional ability to the Health Professions Council, Commonwealth of The Bahamas.-----

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