Initials and Date of Receipt

Health Professions Council of Namibia

P Bag 13387, Windhoek
36/37 Schönlein Street, Windhoek West
Telephone +264 61 245586 / 245928 / 247281 / 245052
/ Fax +264 61 224549 / 271891
e-mail address: nc@hpcna.com.na

NURSING BOARD

Please complete this form in full. Completed forms must be addressed to the Registrar

A
Application for Restoration of a Name to the Register for

_____
(state profession)

Client (Account) No. _____

The following documents (original or certified by a Commissioner of Oaths) must accompany your application:

1. Original or certified copy of Registration Certificate of the country where you are currently employed (Not applicable if employed in Namibia)
2. **Original** Letter of Good Standing (Certificate of Status) from every registering authority covering all countries you have worked in over the last 5 years. The certificate must be issued not more than 120 days before the date of submission of your application. ***Applicable only to practitioners who had left Namibia to practice elsewhere.***
3. The following non-refundable fees are payable:

	Namibian Citizen	**Non Citizen**
Voluntary removal of your name:		
Application for restoration fee	N$ 490.00	N$ 1, 880.00
Issue of a restoration certificate	N$ 230 00	N$ 880.00
Annual maintaining fee	N$ for the current year	
Involuntary removal of your name (e.g. non-payment of annual fee before or on 31 March of a year)		
Application for restoration fee of	N$ 950.00	N$ 3,600.00
Issue of restoration certificate	N$ 230.00	N$ 880.00
Annual maintaining fee	N$ for the current year	
Outstanding annual fees for previous years	N$	

A
PERSONAL PARTICULARS

Surname		Title	Prof./Dr	Mr./Ms
First Names				
Maiden Name		Gender	Male	Female

Bank details: First National Bank of Namibia, Account No. 62073052385, BC 281872
NB! Use your client number as our reference.

Postal Address	
Residential Address	

Telephone	Home		Fax	
	Work		Cell	
	e-mail			

Please print e-mail address clearly

Please note: *In terms of the relevant legislation, any change in residential or postal address must be reported in writing to the Registrar within 30 days of such change taking place.*

B

POSITIONS HELD SINCE REMOVAL OF NAME

Employer/ Hospital/ Practice	Post	Town / City	Country	Start and End Dates

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Employer's address or Business Address (Postal and Street addresses, telephone and fax numbers, e-mail address)	

C

1. I am desirous that my name be restored to the Register for _____
(state profession)
and hereby make oath and declare that I am the person mentioned in the accompanying certificate of registration dated _____ and issued to me by the Council.

2.(a) My name was removed from the Register for the following reason:

☐ I have failed to notify the Registrar of my correct physical address within a period of 3 months after the date of a request for particulars of such physical address by the Registrar

☐ I have requested in writing that my name be removed from the register

☐ I have failed to pay to the Council on or before 31 March of the year concerned the annual fees determined by Council and payable by me

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☐ My name has been removed from the register, record or roll of an educational institution from which I received the qualification by virtue of which I was registered in terms of the Health Professions Act (Act No. 16 of 2024)

☐ I was registered in error or as a result of fraud or in circumstances not authorized by the Health Professions Act, (Act No. 16 of 2024)

☐ I was found guilty of unprofessional conduct and a penalty have been imposed upon me.

☐ A criminal act was instituted against me.

2.(b) I state that –

☐ I have paid the outstanding annual fees.

☐ I have complied with all the conditions/requirements of the penalties imposed upon me.

_____ _____

Signature of Applicant Date

I declare/solemnly affirm under oath that I have never been convicted of any offence under any law or been found guilty of unprofessional conduct in any country, and to the best of my knowledge, no proceedings involving or likely to involve a charge of any such nature are pending against me in any country at the present time.

_____

Signature

Sworn / solemnly affirmed before me at _____on this _____

day of _____ 20 _____

_____

Name

_____

Signature
Commissioner of Oaths

Official stamp

D

Please tick (√) one of the options below

☐ Please send my restoration certificate and practicing card by registered mail to the postal address indicated in Part A of this form

☐ Please do not send my restoration certificate and practicing card by registered mail because I will collect it in person or arrange to have it collected by another person

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