



APPLICATION FOR APPROVAL OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD) ACTIVITIES

NOTE: Activity Programme and Presenter CV's required to be submitted with this application

Please complete and submit for a recommendation to an Accreditor

Name of Providing Organisation and/or Name Of Provider (Including Registration Number)	
Postal Address of Organisation	
Contact Person	
Telephone Number (Incl Area Code)	
Fax Number (Incl Area Code)	
e-Mail Address	
Activity Title	
Date(s) of Activity Programme	
Telephone Number (Incl Area Code)	
Venue (Full Address) of Proposed Activity (If Applicable)	<p style="text-align: right;">Postal</p> <p>code</p>
Level of Proposed CPD Activity	
Registration Fee	
Number of hours Involved	
Suggested CEU's (General)	
Suggested CEU's in Medical Ethics, Human Rights and Legal Issues pertaining to health sciences	

Suggested total CEU's (Indicate Maximum Points In each Level)	
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	Name of Accrerator:

With the submission of this application, I herewith undertake to monitor the attendance per session, evaluate the presentations as specified and to inform the accreditors accordingly. I recognize the authority of the Board/Accreditors to cancel the accreditation on non-compliance to the criteria.

Signature on behalf of PROVIDER Designation:..... Date

FOR THE OFFICIAL USE OF THE ACCREDITOR

This is to certify that(name of Accrerator) -

has agreed to the proposed CPD points as follows:

LEVEL 1	LEVEL 2	LEVEL 3	ETHICS/HUMAN RIGHTS/LEGAL MATTERS

Specify ethical/human rights/legal matters relating to health sciences

TOTAL:

Specify the reasons why the above-named Accrerator does not agree to accreditation:

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SIGNATURE ON BEHALF OF DESIGNATED CPD ACCREDITOR

DATE:

NAME AND DESIGNATION: