**FORM A**

**THE PROFESSIONS SUPPLEMENTARY TO MEDICINE ACT, 1965**

**APPLICATION FOR ADMISSION TO THE REGISTER OF:**

MEDICAL LABORATORY TECHNOLOGY [ ] RADIOGRAPHY [ ]

PHYSIOTHERAPY [ ] OCCUPATIONAL THERAPY [ ]

DIETITIAN/NUTRITIONIST [ ] SPEECH THERAPY [ ]

AUDIOLOGY [ ] PUBLIC HEALTH INSPECTOR [ ]

DIETETIC ASSISTANT [ ] NUTRITION ASSISTANT [ ]

PSYCHOLOGY [ ] CHRIROPODY/PODIATRY [ ]

CYTOLOGY [ ] ULTRASONOGRAPHY [ ]

 CARDIOVASCULAR TECHNOLOGY [ ]

NAME OF APPLICANT:

GENDER: Male [ ] Female [ ] Other [ ]

STATE WHETHER: Single [ ] Married [ ] Divorced [ ] Widowed [ ]

DATE AND COUNTRY OF BIRTH:

NATIONALITY:

CURRENT ADDRESS:

(This should be an address

at which you are certain to receive

communication sent to you)

CONTACT NUMBER (S):

EMAIL:

CURRENT PRACTICE ADDRESS:

(Address of place or institution in

which profession is practiced)

QUALIFICATION(S):

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**FORWARD HEREWITH ARE THE FOLLOWING DOCUMENTS:**

1. CERTIFICATES (OR CERTIFIED COPIES THEREOF):

1. CHARACTER REFERNCES FROM TWO REFEREES- (**One must be from a PERSON in good**

(**Original copies**)  **standing in** **the applicants profession)**

1. ONE PASSPORT SIZE PHOTOGRAPH

**PLEASE STATE:**

1. IS ENGLISH YOUR FIRST LANGUAGE? [ ] YES [ ] NO

1B. If ‘’**NO**’’, you are required to submit a certificate of proficiency in **ENGLISH** issued by an accredited Agency. This certificate must accompany your application.

1. HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENSE? [ ] YES [ ] NO

 (If ‘’**YES**’’ give details)

1. HAVE YOU EVER BEEN FOUND GUILTY OF PROFESSIONAL MISCONDUCT? [ ] YES [ ] NO

 (If ‘’**YES**’’ give details)

1. DO YOU WISH FOR YOUR SIGNATURE TO BE ELECTRONICALLY

GENERATED ON YOUR LICENSE? [ ] YES [ ] NO

**I DECLARE** THAT THE FOREGOING PARTICULARS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE NOT MADE A PREVIOUS APPLICATION AND I HAVE READ THE **COUNCIL’S GUIDANCE OF INFAMOUS ACT**. I ENCLOSE THE FEE OF DOLLARS AND I HEREBY APPLY FOR REGISTRATION IN THE REGISTER AND I PROMISE, IN THE EVENT OF MY BEING REGISTERED, AND IN THE CONSIDERATION THEREOF, TO BE BOUND BY AND TO CONFORM IN ALL RESPECTS TO THE REGULATIONS RELATING TO FOR THE TIME BEING.

SIGNATURE OF APPLICANT DATE

Return completed form to:

**The Registrar,**

**Council for Professions Supplementary to Medicine**

**50 Half Way Tree Road, Kingston 5, Jamaica W.I.**

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| **FOR OFFICE USE ONLY** |
| DOCUMENTS RECEIVED | CERTIFICATE NO. |
| REGISTRATION FEE | DATE COLLECTED OR DISPATCHED |
| REGISTRATION DATE  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **VERIFIED**  | **APPROVED** | **DEFERRED** | **DENIED** |
|  |  |  |  |

1. **NB. FEES SUBMITTED FOR SERVICES FROM CPSM ARE NON-REFUNDABLE**
2. **APPLICANTS ARE REMINDED THAT ANNUAL RE-REGISTRATION IS A REQUIREMENT. RENEWAL PERIOD IS APRIL 1ST TO JUNE 30TH.**