**FORM D**

**PROFESSIONS SUPPLEMEMTARY TO MEDICINE ACT, 1965**

**APPLICATION FOR THE RENEWAL OF LICENSE**

**ALL PROFESSIONS**

1. NAME IN FULL: …………………………………………………………………………………….

(**Surname)** (**Forenames)**

1. MAIDEN NAME …………………………………………………………………………………...
2. RE-REGISTATION AS: ………………………….. ………………………………...

(**Professional Title)**

1. REGISTRATION NO: ………………… ORIGINAL DATE OF REGISTRATION………….............
2. CURRENT HOME ADDRESS: ………………………………………………………….....................

……………………………………………………………………………………………………….

1. CONTACT NO’S: ……………………………………………………………………………………
2. EMAIL ADDRESS: ……………………………………………………………………………..........
3. CURRENT PLACE OF PRATICE: ……………………………………………………………………
4. PRACTICE ADDRESS: ………………………………………………………………………………
5. TELEPHONE NO’s: …………………………………………………………………………………
6. LAST PLACE OF PRACTICE: ………………………………………………………………………
7. TOTAL CONTINUING EDUCATION (CE) CREDITS SUBMITTED: ………………………………...
8. I wish to have my name retained in the register of the Council for the Professions Supplementary to Medicine for the year ……………….. …….as a………………………………………………...

The fee of $............................................. is enclosed.

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**Please note the following:**

1. **Application is not completed until fees are paid.**
2. **Application fees are non-refundable.**
3. **Your license card will be electronically generated.**
4. **Your signature will be electronically generated for the preparation of your license card.**
5. **Your license card is expected to be completed two (2) weeks after approval of application by the Council.**
6. **Your license card will be emailed to you.**

**By signing this form you agree to the terms and conditions of this application.**

SIGNATURE: …………………………… DATE: ……………………………………

The completed form is to be returned to:

**The Registrar,**

**Council for Professions Supplementary to Medicine**

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

**……………………………………………………………………………………………………………**

**For Official Use Only**

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| --- | --- | --- | --- |
| **CONTINUING EDUCATION (CE) CREDITS** | | | |
| **Discipline Specific** | **Non-Discipline** | **Ethics** (**If applicable)** | **Total** |
|  |  |  |  |
| **Approved By:** | **Name of Professional Rep.** | **Signature of Professional Rep.** | **Date Approved** |

Presented for License preparation by:Date of Presentation:

(Name of CPSM staff)

License Prepared by: Date Prepared:

**(**Name of CPSM staff)