THE HEALTH PROFESSIONS AUTHORITY, TURKS & CAICOS ISLANDS
Town Center Mall - 2nd Floor, 23 Parade Avenue, Providenciales, Turks & Caicos Islands, W.I.
Tel: (649) 338-5140 Email: hpaapplications@gov.tc

APPLICATION FOR REGISTRATION

I,.....
First Name Middle Name Last Name

Hereby apply for registration with the: ☐ Allied Health Professions & Pharmacy Professions Council ☐ Nursing & Midwifery Professions Council ☐ Medicine & Dentistry Professions Council

of the Turks & Caicos Islands, by virtue of the following qualifications of which I am lawfully possessed:

Description of Qualifications	Date of Qualifications	Universities	Country

Place and Date of Applicant's Birth: .....

Applicant's Ordinary Address: .....

.....

I DO HEREBY CERTIFY THE ABOVE INFORMATION TO BE TRUE.

Signature: ..... Date: .....

Application fee: $ .....

DECLARATION OF THE APPLICANT

Last name	Other names	Maiden name

Nationality:

Sex	M	F

Contact:

Phone	Email

Profession:

Professional Experience:

Name and Location	Dates	Additional Details

References:

	Name	Title	Address

Employer			
Professional			
Character			

Kindly answer truthfully YES or NO to the following questions. If YES, please enter the details:

	Yes(Y)	No(N)
Are you fluent in the use of the English Language?		
Have you ever been denied an application for licensing, registration, permit, or authority to practise in another jurisdiction?		
If Yes:		
Effective Date of official notice of denial:	State/Province:	
Name of Council/Board	Reason for denial of licence/registration/permit	

	Yes(Y)	No(N)
Have you ever been criminally charged, or convicted, or found guilty of professional misconduct, conduct unbecoming, incompetence or a lack of fitness to practise your profession in another jurisdiction?		
If Yes:		
Effective Date of Council/Board's decision:	State/Province:	
Name of Council/Board:		
Explanation for the pronouncement of guilty of professional misconduct/conduct unbecoming/ incompetence / an incapacity or lack of fitness to practise your profession		

	Yes(Y)	No(N)
Have you ever been suspended or restricted in another jurisdiction or had your licence, registration, permit, or any other authority to practice your profession revoked?		
If Yes:		
Effective Date of Disciplinary Action:	State/Province:	
Name of Council/Board:		
Reason for suspension/revocation/restriction of licence/registration/permit		

	Yes(Y)	No(N)
Are you currently or have you been subject to an investigation or other proceeding in relation to your conduct, competence, or capacity or fitness to practise your profession in another jurisdiction?		
If Yes:		
Date of Investigation/Proceeding:	State/Province:	
Name of Council/Board:		
Explanation of the investigation/proceeding in relation to your conduct/ competence/ capacity/ fitness to practise your profession		
Reason for suspension/revocation/restriction of licence/registration/permit		

List all other Councils/Boards/Organizations where you are registered:

Declaration:

I, ...

do solemnly promise to abide by the laws governing the practice of my profession in the Turks and Caicos Islands, and further promise to observe and abide by the principles and contents of the Guide to Ethical Practice of the Health Professions in the Turks and Caicos Islands, and understand that I will be subject to any sanctions and penalties prescribed by the Health Professions Council if I am found to be in breach of such laws, regulations, and ethical principles.

Signature: ..... Date: .....