



Form CPD 2A

APPLICATION FOR APPROVAL OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD) ACTIVITIES

NOTE: Activity Programme and Presenter CV's are 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/Name of Individual (Including Registration Number)			
Postal Address of Providing Organisation and/or Provider and/or Individual			
Contact Person (Organisation/Provider/Individual)			
Telephone Number (Incl Area Code) (Organisation/Provider/Individual)			
Fax Number (Including Area Code) (Organisation/Provider/Individual)			
e-Mail Address (Organisation/Provider/Individual)			
Activity Title			
Date(s) of Activity/Programme			
Venue (Full physical address) of proposed activity (If applicable)			
Level of Proposed CPD Activity			
Registration Fee involved for participants			
Number of hours Involved			
Suggested CEU's (General)	Level 1	Level 2	Level 3
Suggested CEU's in Medical Ethics, Human Rights and Legal Issues pertaining to health sciences	Level 1	Level 2	Level 3
Suggested number of CEU's (Indicate Maximum Points In each Level)	Level 1	Level 2	Level 3
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	

Organisations/Providers only:

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: ORGANISATION/PROVIDER/INDIVIDUAL

Designation:

Date:

FOR THE OFFICIAL USE OF THE ACCREDITOR

This is to certify that(name of Accreditor) -

has agreed to the proposed CPD points as follows:

Level 1	Level 2	Level 3

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

TOTAL:

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

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SIGNATURE ON BEHALF OF DESIGNATED CPD ACCREDITOR

DATE:

NAME AND DESIGNATION:

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