



THE HEALTH PROFESSIONS COUNCIL OF ZAMBIA

The Health Professions Act, 2009

(Act No. 24 of 2009)

The Health Professions (General) Regulations, 2012

| APPLICATION FOR APPROVAL OF A SPECIALTY TRAINING PROGRAMME | | | |
|---|---|-----------------------------|---|
| <i>Information Required</i> | | <i>Information Provided</i> | ✓ |
| 1 | (a) Name of the Training Institution | | |
| | (b) Name of Faculty (e.g. College of Physician, Surgeons etc.) | | |
| | (c) Nationality (Zambian/Non- Zambian) | | |
| | (d) Ownership (Private/ Public) | | |
| | (e) Physical Address | | |
| | (f) Postal Address | | |
| | (g) District | | |
| | (h) Province | | |
| | (i) Phone No. | | |
| | (j) Email | | |
| | (k) Fax No. | | |
| 2 | PART B (PARTICULARS OF THE SPECIALTY TRAINING PROGRAMME) | | |
| | (a) Name of the Training Programme | | |
| | (b) Level of the Training Programme | | |
| | (c) Duration of the Training Programme | | |
| | (d) Curriculum for the Training Programme | | |
| PART C (PARTICULARS OF A STP HEAD OF TRAINING) | | | |

| | | | |
|--|--|--|--|
| | (a) Name of the STP Head of Training | | |
| | (b) Profession of the STP Head of Training | | |
| | (c) Nationality | | |
| | (d) NRC | | |
| | (e) HPCZ Reg No. | | |
| | (f) Residential Address | | |
| | (g) Phone No | | |
| | (h) Email Address | | |
| | (i) Appointment letter STP Head of Training | | |
| | (j) Curriculum Vitae of STP Head of Training | | |
| PART C (PARTICULARS OF THE STP COORDINATOR) | | | |
| | (a) Name of the Coordinator | | |
| | (b) Profession of the Coordinator | | |
| | (c) Nationality | | |
| | (d) NRC | | |
| | (e) HPCZ Reg No. | | |
| | (f) Residential Address | | |
| | (g) Phone No | | |
| | (h) Email Address | | |
| | (vi) Appointment letter for the Coordinator | | |
| | (vii) Curriculum Vitae of the Coordinator | | |
| PART C (STAFF ESTABLISHMENT AND FACULTY) | | | |
| (a) | No. of Teaching staff on the establishment | | |
| (b) | No of the Teaching Staff Available | | |
| (c) | No. Teaching staff on full time | | |
| (d) | No. of Teaching Staff on Part Time | | |

PART D (BOARD OF DIRECTORS)

| No. | Name | Nationality | NRC No. | % of Shares |
|-----|------|-------------|---------|-------------|
| (a) | | | | |
| (b) | | | | |
| (c) | | | | |
| (d) | | | | |
| (e) | | | | |
| (f) | | | | |

PART E (ATTACHMENTS)

| | |
|---|--|
| <p>4</p> <p>Tick the copies of the documents that have been attached to the application</p> | Photocopy of hospital licence from HPCZ for the training institution |
| | Photocopy of facility licence from HPCZ for the rotational sites |
| | Photocopy of National Registration Card(s) or Passport(s) of Teaching Staff |
| | Copies of registration and practicing certificates for all teaching staff who are health practitioners |
| | MOU with rotational sites |
| | Copies of registration and practicing certificates for all teaching staff who are health practitioners |
| | copy of proof of ownership of premises or if premises are leased, copy of tenancy agreement |
| | MOU or signed contract with sponsor(s) |
| | Appointment letters for all the teaching staff |
| | Contracts for all the teaching staff |
| Valid Practicing certificates for teaching staff who are health practitioners | |

I do solemnly declare that the information provided in this form is correct and true

Applicant's signature Designation Date

FOR OFFICIAL USE ONLY

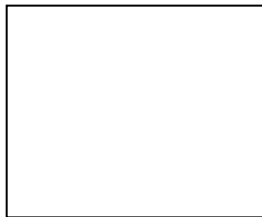
Accounts Department

Payment Received by: _____

Name Officer Designation Signature Date

Date Received _____ Amount Received _____

STAMP



Receipt No: _____

.....
.....
Receiving of Application

Application Received by: _____

Name Officer Designation Signature Date

.....
.....

