Mailing Address:
**Council for Allied Health Professions**,
P.O. Box HM1195
Hamilton HM EX
Bermuda.

Courier Delivery Address:
**Council for Allied Health Professions**
Continental Building
25 Church Street
Hamilton HM12
Bermuda.

## ALLIED HEALTH PROFESSIONS ACT

## APPLICATION FOR REGISTRATION

*Please print all information*

**Application for registration as a/an:** _____

Name: _____
*Last* *First* *Middle*

Address: _____

_____

E-mail Address: _____ Telephone Number: _____

Age: _____ Date of Birth: _____ Nationality: _____

### EMPLOYMENT

Proposed Employer: _____

Proposed Position: _____

Proposed Employer's Address: _____

_____ Telephone Number: _____

### EDUCATION/TRAINING

**List School(s)/University Attended** **Dates of Attendance**

_____ From: _____ To: _____

_____ From: _____ To: _____

**List Professional Degrees, Diplomas or Other Qualifications** **Date Granted**

_____ _____

_____ _____

### POSTGRADUATE EXPERIENCE *(see note #1)*

1. _____
2. _____
3. _____
4. _____

***Answer the following questions. If you answer "yes" to questions 2-6 provide complete details on a separate sheet. Sign and date below***

| | | Yes | No |
|---|---|---|---|
| 1. | Do you hold licensure or are you registered (active or inactive, current or expired) to practice in any other jurisdiction? If yes, list each one. | | |
| 2. | Have you ever withdrawn an application for registration, had an application denied or refused, or agreed not to reapply for registration in another country? | | |
| 3. | Has any disciplinary action been taken against you by any licensing authority? | | |
| 4. | Have you had privileges denied, revoked or restricted in a hospital or other health care facility? | | |
| 5. | Have you been convicted, found guilty or pleaded guilty or non contestant to any offence? | | |
| 6. | Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? | | |

## VERIFICATION OF INFORMATION

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements may result in the revocation of my registration.

Dated this ____ day of _____ 20 ____ _____

Signature of Applicant

**Registration Fee** - A cheque or money order for **BD$29.00** (US$29.00 - twenty-nine dollars) made payable to **THE ACCOUNTANT GENERAL.**

## DOCUMENTATION

The following documents must accompany this application:

1. Offer letter from Bermuda employer (applies to non-Bermudians only)
2. Letter of reference from two previous employers/supervisors (most current and discipline specific),
3. Statement of Experience (c.v.) - (education and employment with dates)
4. One passport sized photograph
5. Letter of Good standing – on official letterhead (an original from the jurisdiction that you have been registered in for the past two years).

**Along with original documents or notarised copies of the following:** (Copies of already notarised copies will not be accepted. If necessary notarised translations in English).

6. Diplomas and Postgraduate Certificates(s) or Letter of Proof of Qualification (Graduation) from relevant learning institution.
7. Birth Certificate or Internationally Recognised Passport
8. Marriage Certificate (where applicable)

9. Professional Association Membership Card or Certificate (if applicable)

10. Proof of current licensure/state registration in current jurisdiction of registration (in cases where this does not exist an official letter is required from the designated authority in that jurisdiction).

**Please forward completed application to**: The Administrative Assistant, Allied Health Professions, P.O. Box HM1195, Hamilton HM EX, Bermuda, or hand deliver to Ministry of Health, Continental Building 25 Church Street, Hamilton HM 12. **Applications should be submitted four (4) to six (6) weeks in advance of professional person arriving in Bermuda.**

**FOR OFFICIAL USE ONLY**

FEE PAID ☐ YES ☐ NO

RECEIPT NO. _____

**APPLICATION APPROVED** ☐

**APPLICATION NOT APPROVED** ☐

SIGNATURE OF **AHP REGISTRAR**: _____ DATE: _____

**COMMENTS:** _____

| **MEETING MEMBERSHIP:** | **NAME** | **PRESENT YES** | **PRESENT NO** | **DATE** |
|---|---|---|---|---|
| **BOARD CHAIRMAN** | | ☐ | ☐ | |
| MEMBER | | ☐ | ☐ | |
| MEMBER | | ☐ | ☐ | |
| MEMBER | | ☐ | ☐ | |
| MEMBER | | ☐ | ☐ | |

***Footnote #1:***

*Respective Boards have the right to recommend to the Allied Health Professions Council, conditional guidelines of practice for any applicant.*

*For example:*

- *the applicant does not meet full criteria for registration*
- *the applicant lacks skill sets or work experience pertaining to the intended area of work*