FORM- II

Ref. No:

# RWANDA ALLIED HEALTH PROFESSIONS COUNCIL
# CONTINUING PROFESSIONAL DEVELOPMENT
## APPLICATION FORM- CPD PROVIDER

**A NON-COMPLIANT APPLICATION WILL BE REJECTED**

**Please PRINT and return the ORIGINAL FORM to:**

**The CPD Coordinator. P.O. Box 6600 Kigali. 4 KG 632 Street. Rugando. Kimihurura or send to info@rahpc.org.rw**

**To be duly completed by the Applicant**

## A. INSTITUTIONAL IDENTIFICATION

Name:……

Physical Address: …….. Sector:……District:……

Street Name & Number: …….. Building/Plot Number: ……

Postal address:……Email: ……

Cell phone: …… Country: ……

Contact Person: …… Contact Tel: ……..

## B. ORGANIZATIONAL STATUS

Public ☐

Private ☐

Non-for-profit ☐

Independent Consultant ☐

**Note: Please ensure all the prescribed requirements are attached to the completed FORM before submission to the Council ( see I. Checklist)**

## C. AREAS OF CAPACITY BUILDING

Basic Medical Sciences ☐ Specify:----------

| | | |
|---|---|---|
| Medical/Dental/ Healthcare Specialisation | ☐ | Specify:---------- |
| Administration/Management/ Quality Assurance | ☐ | Specify:---------- |
| Information and Communication Technology | ☐ | Specify:---------- |
| Medicolegal and Professional Ethics | ☐ | Specify:---------- |
| E-learning | ☐ | Specify:---------- |
| Others | ☐ | Specify:---------- |

## D. EVIDENCE OF PREVIOUS CAPACITY BUILDING ACTIVITIES ( Where Applicable) ( Evidence can be attached)

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## E- LIST OF KEY TOPICS TO BE DELIVERED AS CPD

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## F. LIST OF PROSPECTIVE FACILITATORS

**Note: Please ensure certifiied copy of academic and professional qualifications, CV and any other supportive document are attached submission. All Health Care Professionals must hold VALID LICENCE ( see I. Checklist)**

| Names | Professional Qualification | Proffessional Registration/Licensing Number |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

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## DECLARATION

I authorize the Council to investigate and obtain from me, any person or any organization such information as may be required in relation to this application. I certify that the

statements made by me in this application are true and complete. I am aware that misrepresentation or falsification may result in rejection of my application or withdrawal of Accreditation.

| NAMES & SIGNATURE OF THE HEAD OF THE INSTITUTION or ORGANIZATION | | |
|---|---|---|
| **Names:** | **Signature:** | **Date:** |
| ..... | | |

## I. CHECKLIST (Reception ONLY)

- ☐ Completed Application form
- ☐ All applicable qualifications ( notified copies)
- ☐ Copy of Registration/Licence
- ☐ CVs of Prospective Facilitators

| FOR OFFICE USE ONLY | | |
|---|---|---|
| Received on ..... | Verified ..... | |
| Date ..... | Date ..... | |
| Reference No ..... | Database record ..... | **Note:** |
| Approved ☐ Rejected ☐ | If rejected, reason: | |
| Accreditation Number: ..... | | |
| Areas of Accreditation | | |
| | | |

Signature: Date: