FORM B

MINISTRY OF HEALTH

TRADITIONAL MEDICINE PRACTICE COUNCIL

Passport size photograph (endorsed by the **referees)**

RENEWAL APPLICATION FORM

ALTERNATIVE & COMPLEMENTARY
HEALTH PRACTITIONER

Application Form Licensed Practice Premises

Section I Application Status

NEW ☐ RELOCATION ☐ RE-INSPECTION ☐
RETAIL FACILITY ☐ WHOLESALE FACILITY ☐ MANUFACTURING UNIT ☐
CLINIC / HOSPITAL ☐ WHOLESALE /RETAIL FACILITY ☐
SHINE ☐ VEHICLE ☐ OTHER, specify ……...
HEALING CAMPS ☐ refer to Section V
(Solely registered for Traditional and Alternative Medicine Service)

Section II Your Personal Information

Last Name
First Name
Middle or initial
Title
Date of Birth
Nationality
Place of Birth

Permanent Address
……
……
Tel. No.
Name of Premises (if applicable)

Gender male ☐ female ☐ Marital Status: Married ☐ Single ☐

Section III Declaration of Employment Details

PRESENT OCCUPATION :……

Name of Facility: ……..……

Section IV - Provide list of all Clinical Staff

NAME OF STAFF	PROFESSIONAL REG. NO,	REMARKS / ROLE

Section V Detail of Vehicle

Vehicle Brand Name:……..……

Vehicle Registration No.:……..…..

Name of Owner:……..…..

Signature of Applicant:…….Date:……../……/…….

TECHNICAL REGISTRATION COMMITTEE'S REPORT	COUNCIL'S DECISION
☐ RECOMMENDED ☐ NOT RECOMMENDED ☐ DEFERRED ☐ DEFERRED TO COUNCIL CHAIRMAN'S SIGNATURE:……..... DATE:……..	☐ APPROVED NOT APPROVED ☐ DEFERRED CHAIRMAN'S SIGNATURE:……..... DATE:……

Reasons For the Disapproval:……...……

…….....……....

……..

…….…… ……..

SIGNATURE DATE

FORM A ALT

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Permanent Address
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Tel. No.

Name of Premises (if applicable)

Gender male ☐ female ☐ Marital Status: Married ☐ Single ☐

Section II Educational Background:- Additional Qualifications Obtained (if any)

NAME OF INSTITUTION (CITY AND COUNYRTY)	QUALIFICATION OBTAINED	YEAR: (From – To)
NB: - Submit Certified True Copies of Certificates		

Section III: Work Experience - C.P. D

Professional Practice - Training	Year: (From – To)

Section IV : Record of criminal offence (if any)

Have you ever been convicted of any criminal offence? Yes ☐ No. ☐
If Yes give
Details:……..…….

……

……

CERTIFICATE STATEMENT

CAUTION: This application form is **NOT** intended for "Magical Practices "and "Money Doubling"

I declare that the information on this forms and documents submitted to the Traditional Medicine Practice Council **(TMPC)** of Ghana is provided in good faith and is true, complete and accurate. I understand that any misrepresentation may be the cause for refusal or revocation of Registration. I also pledge to use titles prescribed by the TMPC and to which I am extended. I am liable for sanction when I flout this rule and titles.

……
SIGNATURE OF APPLICANT

DATE……/……/…….……

FOR OFFICE USE ONLY

Background Check Report:……

……...

Signature of investigating officer:…….…….. Date:……

Registration Committee comments:……..

……...

Signature:……. Date:……

Registration committee Report

☐ RECOMMENDED ☐ NOT RECOMMENDED

☐ DEFERRED ☐ REFERRED TO COUNCIL

CHAIRMAN'S SIGNATURE:…… DATE:…..……/….……/……..

Reason(s) for the disapproval or referral above:……

……

Registrar's Signature:…….. Date:……../……../……..