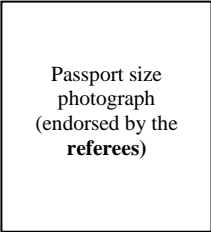


**FORM B**

**MINISTRY OF HEALTH**  
TRADITIONAL MEDICINE PRACTICE COUNCIL



**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  Permanent Address  
 First Name  .....  
 Middle or initial  .....  
 Title  Tel. No.   
 Date of Birth  Name of Premises  
 Nationality  (if applicable)   
 Place of Birth

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**

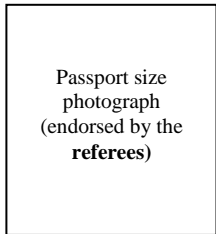
Vehicle Brand Name:.....  
 Vehicle Registration No.:.....  
 Name of Owner:.....

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

TECHNICAL REGISTRATION COMMITTEE'S REPORT	COUNCIL'S DECISION
<input type="checkbox"/> RECOMMENDED <input type="checkbox"/> NOT RECOMMENDED <input type="checkbox"/> DEFERRED <input type="checkbox"/> DEFERRED TO COUNCIL	<input type="checkbox"/> APPROVED    NOT APPROVED <input type="checkbox"/> DEFERRED
CHAIRMAN'S SIGNATURE:..... DATE:.....	CHAIRMAN'S SIGNATURE:..... DATE:.....
Reasons For the Disapproval:..... ..... .....	
SIGNATURE	DATE

**FORM A ALT**

**MINISTRY OF HEALTH  
TRADITIONAL MEDICINE PRACTICE COUNCIL**



**RENEWAL APPLICATION FORM**

**ALTERNATIVE & COMPLEMENTARY  
HEALTH PRACTITIONER**

**Section I Your Personal Information**

Last Name	<input type="text"/>	Permanent Address
First Name	<input type="text"/>	
Middle or initial	<input type="text"/>	.....
Title	<input type="text"/>	.....
Date of Birth	<input type="text"/>	Tel. No. <input type="text"/>
Nationality	<input type="text"/>	Name of Premises (if applicable) <input type="text"/>
Place of Birth	<input type="text"/>	
Gender	male <input type="checkbox"/> female <input type="checkbox"/>	Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/>

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

NAME OF INSTITUTION (CITY AND COUNTRY)	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:...../...../.....