

**REPUBLIC OF NAMIBIA**

**MINISTRY OF HEALTH AND SOCIAL SERVICES**

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| APPLICATION FOR AUTHORIZATION TO PRACTISE A HEALTH SERVICE PROFESSION IN THE EMPLOYMENT OF THE STATE ONLY |

**SECTION A**: DETAILS OF THE APPLICANT (*To be completed by the HEAD of DIVISION*)

NB: Certified proof of all relevant documents must be attached.

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| Surname:  Full Name:  Nationality:  Passport No:  I/D No: |  |
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| Qualifications:  Academic Institution or Training Centre:  Country of Training:  Date of Qualification: |  |
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| Profession for which Authorization is required:  Current or previous Professional Registration: |  |
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| Recommended Area/Health Facility to practice the Health Service Profession:  Recommended Restrictions and Conditions of Authorization: |  |
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NAME AND SIGNATURE OF HEAD OF DIVISION DATE

**SECTION C:**

(To be completed by the relevant HEALT SERVICE PROFESSIONAL BOARD)

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| **COMMENTS** |  |
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PRESIDENT: …………………………………… BOARD DATE

**SECTION D:**

**Comments under Sections B and C Recommended / Not recommended / as amended**

EXECUTIVE DIRECTOR: MINISTRY OF HEALTH AND SOCIAL SERVICES DATE

**SECTION E:**

RECOMMENDATION FOR AUTHORIZATION APPROVED / NOT APPROVED

MINISTER: MINISTRY OF HEALTH AND SOCIAL SERVICES DATE