



Personal Declaration

Please confirm the statement below

I, certify that I am the person applying to the Department of Healthcare Professions for registration, that I am the person named in the submitted documents and that the information I have given is true and correct.

I understand that any license or approval that may result from this application will be void if I have made any false or misleading representations or declaration in this application through error or omission.

I authorize the Department of Healthcare Professions to post my professional information on a publicly - available register of licensed practitioners should my application be successful.

I, the undersigned, certify that the information contained in this application form or accompanying documents is correct to the best of my knowledge and beliefs.

I understand that I will be liable to certain penalties if I fail to comply with the obligation to declare or provide complete or correct information.

Name of Applicant -----

Mobile No-----

Phone No-----

Email-----

Date-----

Signature-----

For official use only

Comments

Date -----

Signature -----