

## ALLIED HEALTH PROFESSIONS COUNCIL OF BRUNEI DARUSSALAM APPLICATION FORM FOR RENEWAL OF PRACTISING CERTIFICATE

**Instructions to Applicant:**

1. Fill in all sections of the Application Form clearly in blue ink.
2. You may be required to submit additional documents or information to the Council upon request.
3. The completed Application Form together with the supporting documents (if applicable) must be submitted to the Council Office during Government working hours at:
 

Allied Health Professions Council of Brunei Darussalam  
Unit 2G4:01, Level 4, Block 2G  
Jalan Ong Sum Ping  
Bandar Seri Begawan BA1311  
Negara Brunei Darussalam
4. Once your application is approved, you will be contacted to come to the Council Office to pay a fee of BND50.00 and to collect your renewed practising certificate.
5. Additional late application penalty fee of BND100.00 will be imposed [Section 19(5) of Allied Health Professions of Brunei Darussalam Order, 2017] for any registrant who applies for a practising certificate later than 30 days before the expiration of the practising certificate.

**AHPCBD REGISTRATION NUMBER:**

(E.g. PT0025, ORT0001)

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<b>I. PERSONAL DETAILS</b>			
Full Name as shown in Brunei I.C. or Passport (IN BLOCK LETTERS):			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Brunei I.C. No. (or Passport No. for non-I.C. holders):	Colour: <input type="checkbox"/> Yellow <input type="checkbox"/> Red <input type="checkbox"/> Green	
Contact Number:	Mobile		Office
Email Address:			
<b>2. EMPLOYMENT DETAILS</b>			
Current Job Title/Position:			
Employer/Company:			
Full Address of Primary Workplace:		Full Address of Secondary Workplace (if applicable):	

3. CPD POINTS ACHIEVED			
Category 1	Category 2	Category 3	Total CPD Points accumulated:
Please state reason(s) for failure to meet annual CPD requirement (if applicable):			
<b>Verified by the Head of Service/Supervisor:</b>  <hr/> <i>(Signature and Date)</i>  <hr/> <i>(Full Name)</i>			<b>Official Stamp of Service/Department/Company:</b>  
4. DECLARATION BY APPLICANT			
Please answer all the following questions:			
<b>(i) Have you ever suffered or are you suffering from any physical or mental illness which may:</b> <b>(a) impair your ability to practise as an allied health practitioner; or</b> <b>(b) require conditions and/or restrictions being imposed on your registration?</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(ii) Have you ever consulted a psychiatrist or are you currently undergoing psychiatric treatment?</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(iii) Are you currently or have you ever been the subject of an inquiry or proceedings by a professional body, health authority or court of law in Brunei Darussalam or elsewhere, involving or relating to any physical or mental illness suffered by you?</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(iv) Are you currently or have you ever been the subject of an inquiry or an investigation by any professional body, licensing authority, health authority or the police, in Brunei Darussalam or elsewhere, the subject matter of which may form the basis of professional misconduct or any improper conduct which may bring disrepute to the allied health profession?</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(v) Have you, at any time before the submission of this application, ever been convicted in a court of law in Brunei Darussalam or elsewhere of any offence?</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(vi) If you have answered 'Yes' to any of the questions, please provide full details and attach supporting documents where applicable:</b>  			

(vii) I declare that the particulars stated in this application and the documents attached are true and authentic, and the information contained herein remains unchanged to date. To the best of my knowledge and belief, I have not withheld any material fact.

(viii) I acknowledge that the Allied Health Professions Council of Brunei Darussalam shall have the right to withhold and/or terminate my registration and/or take any other action it deems fit, if any of the above information or documents tendered is found subsequently to be false. I am also aware that it is a criminal offence to make any false statements, to provide any false information and/or document(s) to the Allied Health Professions Council of Brunei Darussalam. I also understand and give my consent to the Allied Health Professions Council of Brunei Darussalam to make any enquiries or obtain any information & documents that it deems appropriate to establish my fitness to practise.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

FOR OFFICIAL USE ONLY			
Date received:			
Application outcome by Council:	Approved / Not Approved	Reason if not approved:	
Remarks:			
Approved fee payment of:	<input type="checkbox"/> BND50.00 - Practising certificate for 01/11/20 ____ to 31/10/20 ____ (R93012) <input type="checkbox"/> BND50.00 - Practising certificate for 01/01/20 ____ to 31/12/20 ____ (R93012) <input type="checkbox"/> BND50.00 - Practising certificate for _____ to _____ (R93012) <input type="checkbox"/> BND100.00 - Late application penalty fee (R94001)		
Council official stamp:		Date of payment:	
		Receipt number:	
		Received by:	
		Signature:	
		Remarks:	