AHPCBD/005

ALLIED HEALTH PROFESSIONS COUNCIL OF BRUNEI DARUSSALAM
APPLICATION FORM FOR NON-PRACTISING REGISTRANT RETURNING TO PRACTICE

Instructions to Applicant:

1. Fill in all sections of the Application Form clearly.
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) can be submitted to the Council Office during Government working hours at:

   Allied Health Professions Council of Brunei Darussalam
   Unit 2G3:02, Level 3, Block 2G
   Jalan Ong Sum Ping
   Bandar Seri Begawan BA1311
   Negara Brunei Darussalam

4. Once your application is approved, you will receive an email with instructions on how to pay the BND50.00 fee via the OCBS online portal. Your renewed certificate will be issued once payment is verified.

AHPCBD REGISTRATION NUMBER:
(E.g. PT0025, ORT0001)

1. PERSONAL DETAILS				
Full Name as shown in Brunei I.C. or Passport (IN BLOCK LETTERS):				
Gender: ☐ **Male** ☐ **Female**		**Brunei I.C. No. (or Passport No. for non-I.C. holder):**		**Colour of Brunei I.C.:** ☐ **Yellow** ☐ **Red** ☐ **Green**
Contact Number:	**Mobile**		**Home**	
Residential Address in Brunei:				
Email Address:				
2. DETAILS OF APPROVED RETENTION OF REGISTRATION				
Date of First Approved Retention of Registration:				
Current Expiry Date of Approved Retention of Registration:				
3. DETAILS OF CURRENT/PROSPECTIVE EMPLOYMENT				
Job Title/Position:				
Employer/Company:				

Full Address of Primary Workplace:	**Full Address of Secondary Workplace (if applicable):**

Status of Employment:

☐ **Working Full Time (at least 37.5 hours per week)**

☐ **Working Part Time (please specify sessions/hours per week):** _____

Main Nature of Practice (please tick ONE only):

☐ **Providing Clinical/Technical Service**

☐ **Teaching/Education**

☐ **Others (please specify):** _____

Proposed Date of Commencing Practice:

4. DECLARATION BY APPLICANT

Please answer all the following questions:

(i) Are you currently suffering from any physical or mental illness which may: **(a) impair your ability to practise as an allied health practitioner; or** **(b) require conditions and/or restrictions being imposed on your registration?**	☐ **Yes** ☐ **No**
(ii) 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?	☐ **Yes** ☐ **No**
(iii) 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?	☐ **Yes** ☐ **No**
(iv) 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?	☐ **Yes** ☐ **No**

Please note that if you have answered 'Yes' to any of the above questions, the Council may require you to provide information/documentation/Fitness for Practice Certificate.

(v) 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.

(vi) 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:	BND50.00 - Practising certificate for _____ to _____ (R93012)		
Council official stamp and approver's initials:		Date & time of payment in OCBS portal:	
		Verified by:	
		Signature:	
		Remarks:	