ALLIED HEALTH COUNCIL [AHC]
Application Criteria
FORM B1

This form should be completed by all applicant(s), making sure relevant document as listed is attached:

1. AHC Application [ ]

2. Police Character Reference [ ]

3. Two testimonials (proof of good character) [ ]

4. Certified Copies of Relevant Certification [ ]

5. Complete Curriculum Vitae [ ]

6. Valid Work Permit or Permanent Residence [ ]

7. Certified copy of photo identity document [ ]

8. Copy of previous correspondence regarding registration to AHC [ ]

9. Non-refundable application fee of EC$100 plus EC$5.00 for application form [ ]

10. Completed Statutory Declaration [ ]

11. Declared to have read the code of ethics [ ]

12. Good Health Certificate [ ]

(Any person who makes a false declaration is guilty of an offense and is on summary conviction to a fine or imprisonment.)

NOTE: ALL FEES MUST BE MADE TO THE COUNCIL [AHC]

<u>Official additional requirements required by Council</u>

Ref: Criteria & Forms (B1)

The Allied Health Council of Saint Lucia (AHCSL)

Practitioner Application Form

FOR OFFICE USE ONLY

- Date Received: ....
- Receipt Number: ....
- Amount: ....

APPLICATION FOR REGISTRATION IN AN ALLIED HEALTH PROFESSION

(PLEASE PRINT CLEARLY)

A. <u>REGISTRATION REQUESTED</u>

(Please mark the relevant allied health profession clearly; you wish to be registered for under the Health Practitioners Act 2006 Division 2 Allied Health Council.)

ACUPUNCTURIST
AUDIOLOGIST
CHIROPODIST
CHIROPRACTOR
DENTAL HYGIENIST
DENTAL TECHNICIAN
DENTAL THERAPIST
DIETITIAN
EMERGENCY MEDICAL TECHNICIAN
EMERGENCY MEDICAL DISPATCHER
HERBALIST
HOMOEOPATHY
IMAGING TECHNOLOGIST
MASSEUSE
MEDICAL TECHNOLOGIST
NATUROPATHIST
OPTICIAN
OPTOMETRIST
OCCUPATIONAL THERAPIST
PODIATRIST
PSYCHOTHERAPIST
PHYSIOTHERAPIST
PSYCHOLOGIST
REFLEXOLOGY

B. <u>PERSONAL DETAILS</u>

1. Title: Prof/Dr./Mr./Ms. *(Please indicate)*

2. Surname: …………………………………………………………………………..

3. Full First Names ………………….…………………………………………….

4. Nationality: ………………………. *5.* Identity Number: ……………………………

6. Saint Lucia Citizen: YES/NO *(Attach photo page of Saint Lucia Identity Document.)*

7. Non-Saint Lucian Citizen: YES/NO *(Attach photo page of Passport.)*

8. If you are not a Saint Lucian Citizen:

(a) do you hold a valid work permit issued by the Department of Labour that permits you to work in the Health Industry? (Please attach proof); or

(b) do you hold Permanent Residence in Saint Lucia, granted by the Dept of Labour (Please attach proof).

9. Postal Address: ……………………………………………………………………………………………

……………………………………………………………………… Postal Code: ………………………

10. Residential Address: ……………………………………………………………………………………

……………………………………………………………………… Postal Code: ………………………

Telephone (Home): (…………) ……………………………………………………………………

11. Intended Practice Address: ……………………………………………………………………………

……………………………………………………………………… Postal Code: ………………………

Practice Telephone: (…………) ………………………………… Fax: (…………) ……………………

Cell: (…………) …………………………… E-mail: ………………………………………………………

12. Highest secondary school standard attained: ……………………………

(Attach certified copy)

13. Can you speak Creole : Yes/No.

14. In respect of which profession(s) (if any) are you already registered with this Council - indicate Your Council registration number and name the profession(s): ……………………………………………

………

15. In respect of which profession(s) (if any) are you already registered with any other statutory health council - indicate council(s), council registration number(s) and profession(s):

- ……………………………………………………………………………………………………
- ……………………………………………………………………………………………………
- ……………………………………………………………………………………………………

C. EDUCATION AND TRAINING

1. Please indicate the qualification(s) you are submitting in support of your application (certified copies required) as well as the name(s) of and contact detail(s) for the educational institution(s) concerned:

- ……………………………………………………………………………………………………
- ……………………………………………………………………………………………………
- ……………………………………………………………………………………………………
- ……………………………………………………………………………………………………
- ……………………………………………………………………………………………………
- ……………………………………………………………………………………………………

NOTE: The Council reserves the right to inspect original documents.

2. Please indicate the actual duration of each course you indicated under point 1:

- ………………………………………………………………………………………………………
- ………………………………………………………………………………………………………
- ………………………………………………………………………………………………………
- ………………………………………………………………………………………………………
- ………………………………………………………………………………………………………

NOTE: The Council reserves the right to inspect original documents.

3. Please attach a certified copy of your academic record in respect of each course indicated under point 1 above, which record shall provide subjects successfully completed (i.e. pass/fail).

4. Please indicate whether you are/were registered with the Council or whether you previously applied for registration with the Council. If you did, please indicate where and when (and attach copies of possible relevant correspondence) ……………………………………………………………………………

5. You are most welcome to also attach any further documentation or submit information which, in your opinion, is relevant and could be of benefit for the correct evaluation of your application.

6. You are required to submit the prescribed **non-refundable** application fee of:

   (a) Application EC$100.00.

   (b) Form EC$5.00

   (c) On Acceptance Bye Annual FeesEC$__________ before a license is issued.

7. You are further required to submit Police Reference and proof of good character (two testimonials).

I hereby certify that all the information provided and documentation submitted is true and correct.

....

Signature of Applicant *Place* *Date*

Return this application to:

The Chairman/Registrar
Applications for Registration,
Conway Business Centre,
Conway Post Office,
Castries, West Indies.

NB: *(a)* The summary given below lists all the documentation that must be submitted with this application.

Additional information may be required for the profession concerned. If so, such additional requirements are attached to this application form and must also be complied with.

(b) Please call the Council Office at (758)452-6757or email:ahpcstlucia@gmail.com should you require any further information.

(c) It is recommended that your application be sent by registered post, and that you fax the tracking number, marked “Application for Registration”, together with your name and contact details to the Council .

(d) You are advised to keep a copy of your application for your records.

(e) **NO ELECTRONIC APPLICATIONS WILL BE ACCEPTED.**

SUMMARY OF DOCUMENTATION AND FEE TO BE SUBMITTED WITH THIS APPLICATION

Certified copy of the photograph page of your identity document.

Proof of valid Work Permit or Permanent Residence.

Certified copy of highest Tertiary certificate attained.

Certified copies of all relevant qualification certificates/degrees/diplomas for which application is made.

Certified Copy of academic record in respect of each qualification submitted.

Copy of previous correspondence regarding registration.

Non-refundable application fee of EC$100.00. Plus EC$5.00 application form.

Two testimonials plus Police character reference (proof of good character).

Any additional requirements specific to the profession concerned.

All fees must be made submitted to the Council.

ALLIED HEALTH COUNCIL
STATUTORY DECLARATION ACT
FORM 1A

This statutory declaration must be completed by all applicants to the Council.

I, ……………………………………………..……………...………………………………..……………………..

Residing at ……………………………………………………………………

Do hereby declare that I am a member of …………………………………………………………………………

………………………………………………………………………………………..……………………...………
(or as the case may be)

………………………………………………………………………………………………..………………………
(here state the college, faculty or society and was authorized by such to)

………...………

On the …………..………… day of ………….………….   ………………….
Day *Month* *Year*

To practice ……………………………………………………………………………………
(*Subject/Discipline)*

……………………………………………………………………………………………………

As appears on my:……………………………………………………………………………..
(Certificate)

………...
(here specify the diploma, certificate or other document evidence of such authority)

Now produced, Showed and sworn before me undersigned Justice Of the Peace/Notary Public.

Signed:……………………………………………………
Declarant

Declared Before me, this ………………………….. day of …………………….. …………………
Day *Month* *Year*

Signed:…………………………………………………..Seal/Stamp
Justice of the Peace/Notary Public