FORM 1D

PSYCHOLOGY COUNCIL

Upholding Standards, Protecting the People

CONTINUOUS PROFESSIONAL DEVELOPMENT(CPD) APPLICATION FOR PROVIDER CERTIFICATION

1. Name of the provider: ____
2. Address: ____

   ____
3. Application for certification for the year: January___________to December ________________
4. Name of Program (CPD) ____
5. Type of Body/Organization (Provider Category)

   ______ Academic

   ______ Association

   ______ Health Related Professional Body

   ______ Non-Health Related Professional Body (Specify)

   ______ Other (Specify)
6. Have you been a previous Certified Provider? Yes/No
7. Anticipated number of events to be held per year _____________________________________
8. Venue for CPD Program ____

   ____
9. List of Facilitators[1] indicating Licensure status.
10. Completed Facilitators form & an abridged CV[2]
11. Time Table indicating tentative date and mode of delivery[3]
12. CPD Content with objectives and target group[4]
13. Simulations[5] and Practical Session(s) * Evidence of Payment of GHC 1,500

Name of Applicant ....

Signature .... Date .... Contact ....

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[1] Attach Licensure statuses

[2] Attach completed Facilitator form with abridged CVs (2 paged)

[3] Attach Time Table indicating tentative dates and mode of delivery (In-person/Virtual)

[4] Attach Course Content with Objectives and Description

[5] Attach Evidence of Simulation **(if any)** * Evidence of payment of GHC 1,500.00

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FOR FURTHER INFORMATION CALL: PHOne: 0503027254 / 0542293014 / 0303978628

EMAIl:
info@psychologycouncil.gov.gh

FOR OTHER REGISTRATION FORMS PLEASE CHECK

Website: www.psychologycouncil.org.gh

Completed Form and attached Document should be sent to:

THE REGIStRAR
ROOM 20, OlD MINISTRY Of HEAlTH OPPOSIte MINISTRIes Post Office MINISTRIes, ACCRA, GHAnA

GHANA POST GPS: GA-110-3586

Payment Details:

SHORT CODE (ALL NETWORKS)

***222*7270#**

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FORM 1D

FOR OFFICE USE ONLY

Form received by ________________________________ Date: __________________

Checked by ____

Amount Paid ___________ Receipt No __________________________

Signature of Officer _____________________________ Date ___________________

Verified by ____

*Officer's comment & suggestion

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____

____

Signature of Officer _____________________________ Date __________________________

Registrar's Comments:

____

____

____

____

Approved: Yes/No Registration No: ____

Signature & Stamp _____________________________ Date __________________________

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FORM 1D

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LECTURERS FORM FOR COURSE CONTENT ACCREDITATION

1. Name	**Surname** **Others**
2. Contact & Email	
3. Qualification (BA, Masters, PhD) *Indicate the field of study with year of completion	
4. Any advanced Professional course with the last 12 months	
5. Employment History (within the last 24 months)	
6. Area of Specialty Or Practice	
7. Research Interest	
8. GPC Category & Standing	

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Date .... Signature ....

*You are permitted to use extra pages if your information does not fit on this page.