



PSYCHOLOGY COUNCIL

FACILITY/PREMISES LICENSING RENEWAL FORM

Upholding Standards, Protecting the People



IN COMPLIANCE WITH PART 5 OF THE HEALTH PROFESSIONALS REGULATORY ACT, 2013 (ACT 857)

Please refer to the guidelines when completing this application Form

Requirement

1. Name of Facility/Premise:

2. Address:

.....

3. Telephone: Email:

4. Location:

.....

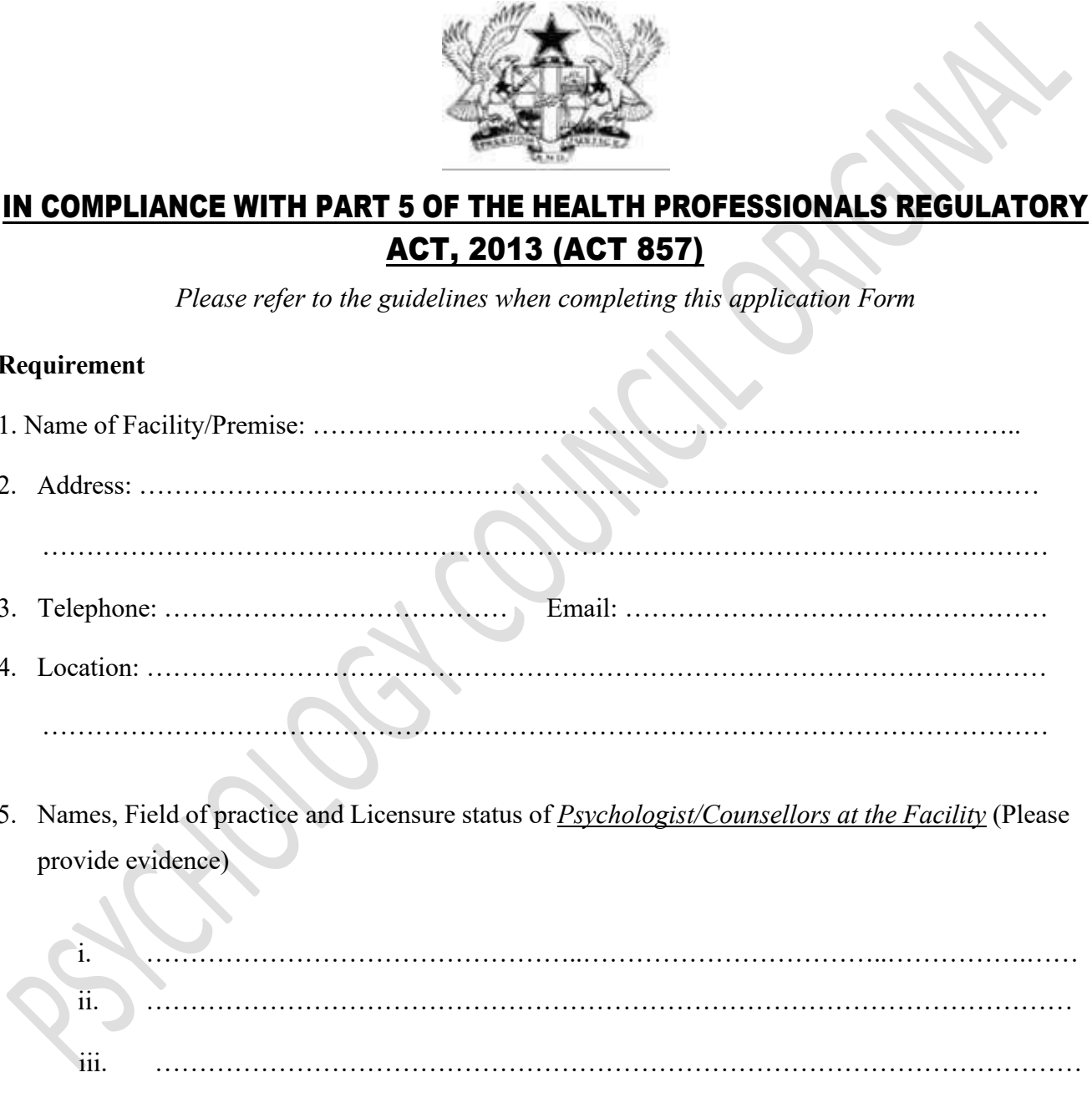
5. Names, Field of practice and Licensure status of Psychologist/Counsellors at the Facility (Please provide evidence)

i.

ii.

iii.

iv.



6. Practitioner category (Please indicate the number of different categories of practitioners according to their level of training).

CATEGORY	NUMBER AT POST
Therapy (Professional)	
Para-professional	
Psychologist Assistant	
Lay Practitioner	

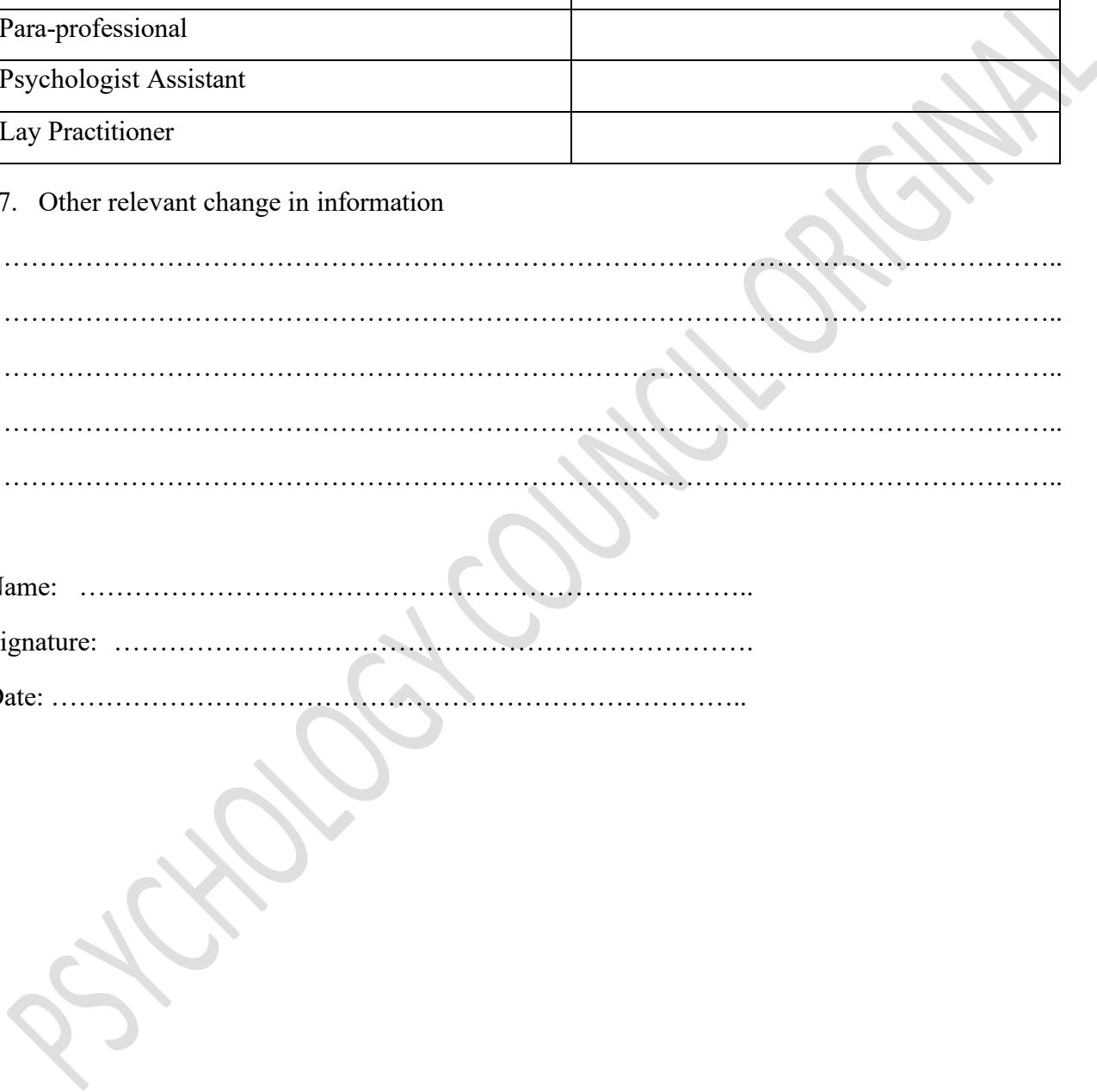
7. Other relevant change in information

.....
.....
.....
.....
.....

Name:

Signature:

Date:



**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#**

FOR OFFICE USE ONLY

Form received by _____ Date: _____

Checked by _____

Amount Paid _____ Receipt No _____

Signature of Officer _____ Date _____

Verified by _____

*Officer's comment & suggestion

Signature of Officer _____ Date _____

Registrar's Comments:

Approved: Yes/No _____ Registration No: _____

Signature & Stamp _____ Date _____