



GHANA PSYCHOLOGY COUNCIL

Upholding Standards, Protecting the People



CONTINUING 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 Facilitators¹ indicating Licensure status.
10. Completed Facilitators form & an abridged CV²
11. Time Table indicating tentative date and mode of delivery³
12. CPD Content with objectives and target group⁴
13. Simulations⁵ and Practical Session(s) * Evidence of Payment of GHC 1,500

Name of Applicant

Signature Date Contact

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

FURTHER INFORMATION

Phone: 0503027254 OR 0542293014

EMAIL: info@gpc.gov.gh OR

PLEASE CHECK

Website: www.ghanapsychologycouncil.gov.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

Bank Details:

GHANA Psychology Council

FIDELITY BANK

RIDGE TOWERS, ACCRA, BANK

Account No.: 1050031790015

OR

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 _____



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FACILITATORS FORM FOR CPD

1. Name	<p style="text-align: center;">Surname Others</p>
2. Contact & Email	
3. Qualification (BA, Masters, PhD) *Indicate the field of study	
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	

Date

Signature