



PERSONAL DETAILS

Title Mr Mrs Miss Ms Dr

Registration No: 90- _____

Full Name _____
First Names _____ Surname _____

Official confirmation of successful completion must be from your Course Co-ordinator, Programme Leader or HoD. **(Not from Graduate / Doctoral / Administration officer)**

Emailed directly to Board:

REGISTER DETAILS – Information not available to the public – required under Section 140

POSTAL ADDRESS FOR THE REGISTER:

RESIDENTIAL ADDRESS:

EMPLOYER:

WORK ADDRESS:

CONTACT INFORMATION – Please complete all sections

Telephone Numbers Work _____ Ext. _____ Home _____ Mobile _____
(Include area codes)

Email Address _____

SCOPE OF PRACTICE SOUGHT

Tick the scope of practice you are seeking to upgrade to.

Psychologist

Counselling Psychologist

Clinical Psychologist

Educational Psychologist

Signature _____ Date: _____