THE MEDICAL REHABILITATION THERAPISTS (REGISTRATION) BOARD OF NIGERIA

CPD PROVIDER APPLICATION FORM A

CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROGRAMME

** INSTITUTIONS **

Passport Photograph

Name of Institution: …………………………………………………………

Residential Address:………………………………………………………………

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

Email address: ………………………………………………………………...

Telephone No.: ……………………………Fax:…………………………………..

Number of CPDs previously organized………………………………………….

Name of department organizing the CPD……………………………………….

Name of HOD…………………………………………………………………

Phone number of HOD………………………………………………………

<u>CPD PROFILE</u>

Title of proposed CPD…………………………………………………………......

……………………………………………………………………………………..

Duration of CPD:……………………………………………………………………...

Number of expected facilitators……………………………………………………..

Expected number of participants…………………………………………………

OFFICIAL USE

Please tick as appropriate

Year of Registration as CPD provider	☐ Adequate	☐ Inadequate
Payment of Registration fees as CPD Provider	☐ Adequate	☐ Inadequate
Registration of Individual CPD Facilitator	☐ Adequate	☐ Inadequate
Submission of Facilitators profile	☐ Adequate	☐ Inadequate
Submission of CPD course content	☐ Adequate	☐ Inadequate
Approval	☐ Approved	☐ Not Approved

Numbers of Credit Units allotted…………………………………………………

Payments Required:- Application Form…………………………………………….

Accreditation……………………

……………………………………………………..

Registrar's Name

……………………………………… ………………………………….

Signature ***Date***