



**THE MEDICAL REHABILITATION THERAPISTS  
(REGISTRATION) BOARD OF NIGERIA**

**CPD PROVIDER APPLICATION FORM B**



Name of Corporate Body: .....

Residential Address: .....

Postal Address: .....

Email address: .....

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

Year and evidence of Registration with Government (CAC No.).....

Number of CPDs previously organized.....

Type of CPDs previously organized.....

Objectives of Present CPD

.....

CPD PROFILE

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 NotApproved

Numbers of Credit Units allotted.....

Payments Required:- Application Form.....

Accreditation.....

.....

*Registrar's Name*

.....

*Signature*

.....

*Date*