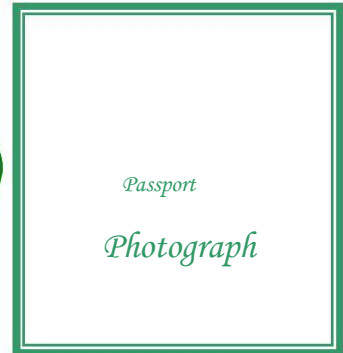




**THE MEDICAL REHABILITATION THERAPISTS  
(REGISTRATION) BOARD OF NIGERIA**

**CPD PROVIDER APPLICATION FORM C**



Name of Society: .....

Chapter: .....

Location/ Address: .....

Postal Address: .....

Email address: .....

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

Number of CPDs previously organized.....

Name of Chapter President Signature of Chapter President

.....

Name of chapter secretary signature of chapter secretary

.....

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*