



IPPC Examination Waiver Application Form

Certified Health Care Professionals Association (CHCPA)

International Physician Proficiency Certification

(Examination Waiver Route)

*Application Fee: US\$200 (Non-refundable)

PERSONAL DETAILS

Mr Mrs Miss Ms Other, please state: _____

First Name: _____

Surname: _____

Preferred Name (for certificate): _____

Gender: Male Female

Date of Birth: ____ / ____ / ____ (DD/MM/YYYY)

Passport Number: _____

Medical Practitioner License No. (Local): _____

Issuing Authority: _____

License Expiry Date: ____ / ____ / ____ (DD/MM/YYYY)

Please write your full name as you would like it to appear on your certificate.

PLEASE COMPLETE THIS ADDRESS PANEL USING BLOCK LETTERS

Home Address

Address Line 1: _____

Address Line 2 (if applicable): _____

Suburb/Town/City: _____

Province: _____

Postcode: _____

Country: _____

Home Phone: _____

Mobile: _____

Home Email: _____

Business Address

Business Name (Affiliated Medical Institution): _____

Address Line 1: _____

Address Line 2 (if applicable): _____

Suburb/Town/City: _____

Province: _____

Postcode: _____

Country: _____

Business Phone: _____

Business Fax: _____

Business Email: _____

Preferred mailing address: Home Business

Preferred email: Home Business

IPPC EDUCATIONAL ASSESSMENT DETAILS

Have you received the qualified IPPC Educational Assessment Result?

Yes No

If yes, complete the following

Assessment Reference Number: _____

Date of Receiving Assessment Result: ____ / ____ / ____ (DD/MM/YYYY)

Assessment Notification Email: _____

Within 6-month validity period for waiver application:

Yes No

DECLARATION QUESTIONS

Have you previously applied for IPPC certification/CHCPA membership?

Yes No If yes, previous Application ID/Member ID: _____

Have you ever been refused admission to IPPC certification or any medical professional body?

Yes No

Have you any criminal convictions related to medical practice?

Yes No

Have you been the subject of an unfavourable decision by a medical professional body/Regulator? Yes No

Please provide details in a signed attachment if any answer is "Yes"

MEDICAL EDUCATIONAL QUALIFICATIONS

(Attach certified true copies of degree certificates and academic transcripts)

QUALIFICATION (e.g. MD, Bachelor of Medicine)	NAME OF MEDICAL INSTITUTION	COUNTRY	GRADUATION DATE (DD/MM/YYYY)

CLINICAL WORK EXPERIENCE

(Where space is insufficient, please include extra details in a signed attachment.)

EMPLOYMENT POSITION	NAME OF MEDICAL INSTITUTION	COUNTRY	FROM (DD/MM/YYYY)	TO (DD/MM/YYYY)	TOTAL YEARS/MONTHS

Total Cumulative Clinical Experience: ____ Years ____ Months

MEMBERSHIP OF OTHER MEDICAL PROFESSIONAL BODIES

(Attach certified copy of current membership certificate and copy of current paid invoice.)

PROFESSIONAL BODY	MEMBERSHIP STATUS	FROM (DD/MM/YYYY)	TO (DD/MM/YYYY)	MEMBERSHIP NO.

DECLARATION

I hereby apply for the IPPC Examination Waive of the Certified Health Care Professionals Association (CHCPA) and if approved, agree to abide by all CHCPA Pronouncements, Code of Medical Ethics and By-Laws. I certify that the information provided on this application form and all attached documents is true, accurate and complete.

I acknowledge that the IPPC Examination Waiver Application Fee of US\$200 is non-refundable regardless of the application outcome. I confirm that I meet at least 3 of the IPPC application eligibility criteria and possess the relevant medical qualifications, clinical experience and professional certifications as required by CHCPA.

I understand that IPPC certification is a professional proficiency credential and does not equate to clinical practice license in the US or other countries; additional local licensing requirements apply for clinical practice.

Signature of Applicant: _____

Date: ____ / ____ / ____ (DD/MM/YYYY)

PAYMENT DETAILS

IPPC Examination Waiver Application Fee: US\$200

After sending this form to the email address: ippc@chcpa.org, please pay the application fee of US\$200 at Step 2: Two Tracks, Track 2: Exam Waiver Application.

APPLICATION CHECK LIST

- Complete and sign the application form
- Certified true copy of qualified IPPC Educational Assessment Result notification
- Certified true copies of medical qualification certificates and academic transcripts
- Certified true copy of valid local Medical Practitioner License
- Original employer testimonials validating 3 years relevant clinical experience / 2 client statements (if self-employed)
- Certified copies of other medical professional body membership certificates and paid invoices
- Attach a comprehensive professional resume
- Certified true copy of passport (photo and personal details page)
- Passport-sized coloured photograph (white background)
- 2-3 letters of recommendation issued by relevant industry experts
- Other supporting documents for this examination waiver application
- Payment/payment details for the US\$200 application fee

ADMISSIONS

CHCPA may approve an applicant who applies in writing on this form, pays the prescribed application fee and provides suitable certified documentary evidence. Certified true copy denotes the verification that your photocopied document is a true copy of the original sighted by any person authorised to verify the authenticity of documentation, such as a Notary Public, or a member of a recognised Medical Professional Body. Where evidence documents were issued to you under a different name, please provide certified true copies of evidence of change of name.

CONTACT DETAILS

Email: ippc@chcpa.org