



Stellenbosch
UNIVERSITY
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forward together
sonke siya phambili
saam vorentoe

Departmental Form 2025



Postgraduate Diploma

In

Family Medicine

Division of Family Medicine & Primary Care

Contact: Ms Nicole Cordon-Thomas
Department of Family and Emergency Medicine
Division of Family Medicine & Primary Care
Tel: 021 938 9168
E-mail: nicolec@sun.ac.za

A PERSONAL INFORMATION

Surname:

First Name:

Identity Number / Passport Number:

Basic Qualification:

Institution Obtained:

Year Obtained:

MP Number:

Courier Address Street:

Postal Code:

City:

Country:

Post Box Address (This Will Not Be Used by The Courier Service):

Postal Code:

Contact Number (1) **(Required)**: _____

Contact Number (2): _____

Email Addresses **(Required)**:

**A1. Why do you want to pursue this postgraduate course in Family Medicine?
Write a paragraph below in English, motivating your reasons.**

B ACADEMIC LANGUAGE ABILITY

Did you graduate MBChB in South Africa? Yes /
No

Was your undergraduate course presented in English? Yes / No

Did you complete the IELTS (International English Language Test? Yes /
No

If English is/was not the medium of instruction during your under- and/or postgraduate studies, you may be required to provide evidence of your English Language proficiency in the form of a formal, recognised English Language placement test result.

C ENROLLMENT INFORMATION

C1. Will you be enrolled for any other courses or engaged in any other studies, at the same time as this course?

C2. Please indicate if you have previously been enrolled in this course or similar course (i.e., DipFamMed or MFamMed) at any University or institution?

C3. Health Professions Council of SA Registration (or equivalent):
(Please attach a certified copy of your registration certificate)

- Registration
no: _____
- Country of registration: South Africa /
Other _____
- Category of registration:

C4. Please indicate if you have previously been the subject of a disciplinary hearing with your employer or registration body?

D ENROLLMENT INFORMATION

Describe where you will be working and what you will be doing during the upcoming 2-years. Please refer note that you must be in a primary care setting **(GP practice / Clinic / District Hospital)** with ambulatory care exposure for this course's outcomes.

	Name of Facility	Post / Job title	Type of experience (see definitions below)
Year 1			
Year 2			

Type of experience:

- Primary care – seeing ambulatory acute and chronic patients in a health centre, clinic or general practice.

- District hospital – working in a hospital run by generalists or family physicians with male, female, paediatric, maternity AND emergency services.
- Other – should be explained.

E INTERNET ACCESS AND COMPUTER SKILLS

- E1 Do you have a personal computer / laptop with Windows?
Yes / No
- E2 Do you have internet access with ADSL / 3G dongle?
Yes / No

F REFERENCES

Please provide us with three referees who have worked with you recently and can speak of your professional ability. They should be accessible by phone, email and must respond quickly to a request for a reference from the University. One should be your current superintendent or supervisor if you have one. Please do not give relatives as references.

Name	Contact Number (Required)	Email Address (Required)

G MARKETING FEEDBACK

How did you hear about the programme (please tick below)? Advert in

CME journal

Advert in SA Family Practice Journal

Leaflet

Internet search / Website

Word of mouth Other

☐
☐
☐
☐
☐
☐

If other, please specify.....

All applicants must submit an official university application form via the University's electronic application system. Your application will be considered as soon as we receive all your supporting application documents.

If we do not receive all your documents by the closing date via the University's electronic application system, your application will unfortunately not be considered. Your application documents as well as proof of payment (where applicable) must be uploaded online before the closing date.

Please note that failure to properly answer all the questions in this form or to provide the other forms required will delay and may even prevent your successful application.

I hereby certify the aforementioned information is complete and accurate.

I declare that the University is entitled to cancel my registration immediately should it become apparent that any of the particulars furnished above in this departmental form is/are untrue or incorrect.

I declare that I have read the programme brochure and course regulations contained therein.

SIGNATURE OF APPLICANT

DATE