



ETDPSETA Moderator Extension of Scope Form

PURPOSE

This form is for the use of moderators who are currently registered with ETDPSETA but would like to extend their scope with ETDPSETA.

*Please be advised that you first need to extend your scope as an assessor, then as a moderator.

APPLICANTS DETAILS

| | |
|-------------------------------|--|
| Title: | |
| Full name as per ID: | |
| Surname: | |
| Initials: | |
| RSA ID Number: | |
| Alternative ID Number: | |
| Nationality: | |

CONTACT DETAILS

| | |
|--|--|
| Fax No: | |
| Cell Phone No: | |
| Email Address: | |
| Preferred Communication Method: | |

BUSINESS ADDRESS

| | |
|---------------------|--|
| P.O Box: | |
| City: | |
| Postal Code: | |
| Province: | |

QUALIFICATION OR UNIT STANDARD

List certificates, skills programmes and unit standards which you wish to **extend your current moderator scope**.

| Qualification /s | SAQA ID | Qualification Title |
|------------------|---------|---------------------|
| | | 1. 2. |
| Unit Standards | SAQA ID | Unit Standard Title |
| | | |
| | | |
| | | |

ETD EXPERIENCE

***Specify your experience in your area of expertise to moderate learners in the related unit standard(s) and/or qualifications for which the registration is required.**

| NAME OF ORGANISATION | WORK EXPERIENCE | JOB TITLE | PERIOD | |
|----------------------|-----------------|-----------|--------|----|
| | | | yyyy | mm |
| | | | yyyy | mm |
| | | | yyyy | mm |
| | | | yyyy | mm |

CRITICAL DOCUMENTS SUBMISSION*PLEASE TICK**

NB: The following supporting documents must be submitted with the application otherwise the application will be declined.

Certified copies of qualification(s)(Certificates, diploma, degree, etc)

Yes

No

Current curriculum Vitae (evidence of extension of scope additional qualifications/unit standards)

Yes

No

DECLARATION OF AUTHENTICITY BY APPLICANT

This section needs to be completed by the moderator

I hereby declare that the information supplied is true and correct.

Signature
(Moderator Candidate)

Date

DECLARATION OF AUTHENTICITY BY PROVIDER REPRESENTATIVE:

This section should be completed by the provider representative. (if linked to a provider)

I hereby declare that the information supplied by the applicant is true and correct.

Name & Surname
Provider Representative

Date

(For office use only)

| | |
|-------------------------------|--|
| Moderator Type | |
| Moderator Registration Number | |
| Registration Start Date | |
| Registration End Date | |