

(Reg.10 (1))

APPLICATION FOR REGISTRATION AS A CERTIFIED AUDITOR

SECTION1: PERSONAL INFORMATION

Surname

Forenames

Mailing Address

E-Mail Address

Date of Admission as BICA Member

Membership Number

SECTION 2: CONDITIONS FOR ISSUE

An application for a practicing certificate must comply with the following conditions:

1. I undertake not to practice without adequate professional indemnity insurance, details of which are herewith attached.
2. I undertake to have regard to the International Guidelines and Statement of Guidance on Ethics as approved by the Council of IFAC and as endorsed by the Council of the Institute.
3. I acknowledge my duty to the public to ensure that the quality of my knowledge and service is maintained after qualification. I therefore, accept my responsibility to undertake adequate Continuing Professional Development as recommended by the Council of the Institute from time to time.
4. I undertake to be mindful of the need to make arrangements for the continuity of the practice in the event of my death or incapacity, details of which are herewith attached.

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SECTION 3: EXPERIENCE

- a) My appropriate audit and accountancy experience was obtained in the office of a BICA Certified Auditor.

Name of Certified Auditor

Name of Firm

Mailing Address of Firm

Telephone

Fax

E-mail

- b) I have no objection to the Institute seeking direct confirmation of my audit and accountancy experience from person/firm enumerated in from in 1 (a) above.

YES

NO

SECTION 4: MEMBERSHIP ADMISSION ROUTE

a). **BICA Qualification**

YES

NO

If yes, no further requirements needed

b). **IFAC Accountancy body**

YES

NO

If yes, please provide /attach evidence of being conferred to meet the requirements to engage in public practice as an auditor by the professional body.

SECTION 5: PRACTICING DETAILS

1. Date you intend to commence practicing under Accountants Act, 2010

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2. (a) Intends to practice:

As a sole practitioner: YES NO

As a partner: YES NO

(b) Intend to be:

In full practice: YES NO

In spare time practice: YES NO

3. Title of Firm

Principal place of business

Mailing address of Firm

Telephone

Cellphone.....

E-mail

Other places of business

4. Partners: If you are not a sole practitioner, please indicate the name(s) of *all* your partners (*including yourself*) with their designatory letters. (Please use **BLOCK CAPITALS)**

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SECTION 6: JOB CATEGORY

Which one of the categories listed below best describes your work?

- General Practicing Services YES NO

