SA Society of Obstetricians & Gynaecologists

P O Box 2127, Cresta, 2118 Tel: (011) 340 9000 Fax: (011) 782 0270

Please forward completed information to:
HealthMan, P O Box 2127, Cresta 2118, or Fax: (011) 782 0270

CONFIDENTIAL

TITLE	
SURNAME	
FIRST NAMES	
GENDER	**MALE / FEMALE**
POSTAL ADDRESS	
PRACTICE ADDRESS (Physical)	
PRACTICE NUMBER (BHF)	
HPCSA REG. NUMBER	**MP**
IDENTITY NUMBER	

PRACTICE DETAILS

PRACTICE TELEPHONE NO.	**( )**
PRACTICE FAX NO.	**( )**
CELLULAR PHONE NO.	
E-MAIL ADDRESS	
Hospitals at which you practice (include day clinics and Medicross)	______ ______ ______
Do you qualify as a:	**Full Time Private Practitioner** **Public Service** **Registrar** **Overseas** **Retired**
COSTS:	**Private Practice: R228 (VAT incl)** **Public Service: R627 per year (VAT incl)**

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ACB AUTHORITY

We hereby request that you make withdrawals from my bank account on the date(s) specified below or at any other time stipulated in the event of there not being sufficient funds in my account.

NAME OF ACCOUNT HOLDER ________________________________

PRACTICE NO. ________________________________

BANK DETAILS

TYPE OF ACCOUNT **CURRENT:** ________________

SAVINGS: ________________

NAME OF BANK ________________________________

BRANCH ________________________________

ACCOUNT NO. ________________________________

BANK CLEARING CODE ________________________________
(top right corner of cheque)

AMOUNT TO BE CHARGED MONTHLY FROM: ________________________________

The company will charge my account on the 1st (first) and on the same day of each month thereafter.

It is hereby agreed that this authority will remain in force until cancelled in writing.

SIGNED AT ……………………………………………….. on ……………………………………… 2009.

____
Signature