Unit 16 Northcliff Office Park
203 Beyers Naude Drive
Northcliff, 2115
Tel: 011 340 9000
Fax: 011 782 0270
PO Box 2127
Cresta
2118

NEUROSURGEON MEMBERSHIP APPLICATION

I, the undersigned hereby apply to take up membership in the Society of Neurosurgeons of South Africa (SNSA). Private Practitioners will receive HealthMan and SAPPF (South African Private Practitioners Forum) membership as part of their SNSA membership.

SIGNED at____________________________ this ________________day of _____________________20___.

Signature: ______________________________

NOTE:

Membership information, to be completed by the applicant (or each partner in the event of a group practice). The information below is necessary in order to prepare a complete members database. Please complete in full. Retain a copy for your records. The majority of communications is by e-mail and sms notifications.

TITLE		
SURNAME		
FIRST NAMES		
POSTAL ADDRESS		Code:
PRACTICE / PHYSICAL ADDRESS		
PRACTICE NAME		
IDENTITY NUMBER	PRACTICE NUMBER (BHF),(PCNS)	HPCSA REGISTRATION NUMBER

VAT REGISTRATION NUMBER	EMAIL ADDRESS

PRACTICE TELEPHONE NO.	PRACTICE FAX NO.	CELLULAR NO.

MEMBERSHIP TYPE	Fulltime Private Practice ☐R371	Public ☐R100
	Limited Private Practice ☐	Registrar (free) ☐
SUB-SPECIALTY *(if applicable)*		

Please Fax Back to 011 782 0270

Banking Details:
Account Name: Health Management & Networking Services (Pty) Ltd
Bank: ABSA Northcliff
Account Number: 4046 954 803

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Written Authority and Mandate for Debit Payment Instructions

This signed Authority and Mandate refers to our contract dated _____________________ ("the Agreement").

I/We hereby authorise you to issue and deliver payment instructions to your Banker for collection against my/our above-mentioned account at my/our above-mentioned Bank (or any other bank or branch to which I/we may transfer my/our account) on condition that the sum of such payment instructions will never exceed my/our obligations as agreed to in the Agreement and commencing on ____________________ and continuing until this Authority and Mandate is terminated by me/us by giving you notice in writing of not less than 20 ordinary working days, and sent by prepaid registered post or delivered to your address as indicated above.

The individual payment instructions so authorised to be issued must be issued and delivered monthly.

In the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day. Payment Instructions due in December may be debited against my account on _____*NA*_____________________*(date).*

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I also understand that details of each withdrawal will be printed on my bank statement. Such must contain a reference number, which must be included in the said payment instruction and if provided to me should enable me to identify the Agreement. This number must be added to this form before the issuing of any payment instruction.

Mandate: I/We acknowledge that all payment instructions issued by you shall be treated by my/our below-mentioned Bank as if the instructions have been issued by me/us personally.

Cancellation: I/We agree that although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to you.

Assignment: I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.

You will be notified within 30 days of the next debit order payment of any fee increases for your membership.

Your debit order will then automatically be adjusted to reflect these increases.

Payment to (Company name) Registered abbreviated company name	***HEALTHMAN***
Name of account holder	
Address of account holder	
Practice number	
Banking details	
Name of Bank:	Type of Account:
Branch Name:	Branch code:
Account number:	Amount:….□R371 □R100

Signe at _____________________________ on this _____day of _______________________________

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____
(Signature as used for operating on the account)

Please attach a cancelled cheque/ proof of banking details. Please ensure you complete the membership application form AND the written authority for debit order payment instructions.

Please fax back to 011 782 0270 or email hillary@healthman.co.za