THE SOUTH AFRICAN SOCIETY OF OTORHINOLARYNGOLOGY HEAD AND NECK SURGERY and MANAGEMENT GROUP

Unit 16, Northcliff Office Park, 203 Beyers Naude Drive, Northcliff, Johannesburg, South Africa, 2115
M: +27 (0) 66 421 6389 **T:** +27 (0) 11 340 9000 **e:** admin@entsociety.co.za

NEW MEMBERSHIP APPLICATION

Kindly mark the X in black

TITLE: [X] *MR* [X] MRS [X] DR [X] PROF **INITIALS:**

KNOWN AS: **SURNAME:**

FULL NAMES:

ID NUMBER OR PASSPORT NO: **DATE OF BIRTH:**

Sponsors require us to indicate the following fields for the purposes of BBBEE certification:

RACE: [X] *AFRICAN* [X] *ASIAN* [X] *COLOURED* [X] *INDIAN* [X] *WHITE* [X] *OTHER* [X] *UNKOWN*

GENDER: [X] *MALE* [X] *FEMALE* **NASIONALITY:**

UNIVERSITY: [X] *CAPE TOWN* [X] *FREE STATE* [X] *KWAZULU-NATAL* [X] *LIMPOPO* [X] *PRETORIA*
[X] *SEFAKO MAKGOTHO* [X] *STELLENBOSCH* [X] *WALTER SISULU* [X] *WALTER SISULU (MTHATHA)* [X] *WITWATERSRAND*
[X] OTHER _____

PHYSICAL ADDRESS: *UNIVERSITY OR FOR PRIVATE PRACTICE*	**POSTAL ADDRESS:** POSTAL ADDRESS
POSTAL CODE:	POSTAL CODE:
PROVINCE: [ ] EASTERN CAPE [ ] FREE STATE [ ] GAUTENG	[ ] EASTERN CAPE [ ] FEE STATE [ ] GAUTENG
[ ] KWAZULU-NATAL [ ] LIMPOPO [ ] MPUMALANGA [ ] NORTHERN CAPE	[ ] KWAZULU-NATAL [ ] LIMPOPO [ ] MPUMALANGA
[ ] NORTHWEST [ ] WESTERN CAPE	[ ] NORTHERN CAPE [ ] NORTHWEST [ ] WESTERN CAPE

HPCSA PROF NR: MP **PRACTICE NR:** (BHF), (PCNS): **VAT REG NR:**

PRACTICE TEL NO: **MOBILE NO:**

EMAIL ADRESS: *TO RECEIVE YOUR PERSONAL COMMUNICATIONS*

EMAIL ALTERNATIVE:

[ ] *PRACITCE* [ ] *PERONAL* [ ] *HOME*

TYPE OF MEMBERSHIP:

[ ] Private Practice [ ] First Year Private Practice [ ] Public Service [ ] Limited Private Practice
[ ] Registrar [ ] Supernumerary Registrar [ ] Medical Officer [ ] Temporary Away
[ ] Overseas [ ] Audiologist & Associate [ ] OTHER _____

IF QUALIFIED ENT SURGEON INDICATE YOUR SPECIAL INTEREST:

[ ] GENERAL ENT [ ] HEAD AND NECK [ ] LARYNGOLOGY [ ] PAEDIATRIC ENT
[ ] OTOLOGY AND NEURO-OTOLOGHY (LATERAL SKULL BASE) [ ] RHINOLOGY AND ANTERIOR SKULL BASE
[ ] RHINOPLASTY AND FACIAL PLASTY [ ] OTHER _____

I, _____ ***hereby declare that I am currently a member of the Society for ORL-HNS and the ENT Management Group and that my details regarding membership are correct.***

SIGNED AT _____ ***on this*** _____ **day of** _____ **20** _____

SIGNATURE:

Please note: Membership information must be completed by the applicant (each partner in the event of a group practice). The information required is necessary to compile a complete member's database. Please complete in full and retain a copy for your records. The majority of communications will be by e-mail and What's App. Please consider the optional completion of the ACB authority page, which will provide authorization for your membership fee to be paid by monthly debit order.

Please complete & email to admin@entsociety.co.za for attention Janette

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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 abovementioned 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 number which is your practice number, which must be included in the said payment instruction and if provided to me should enable me to identify the Agreement.

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:	***Ear Nose and Throat Management Group Limited*** ENT
Name of Account holder:	
Address of Account holder:	
Practice number:	

Banking details

Name of Bank:		Type of Account:	
Branch Name:		Branch code:	
Account number:			

Monthly Amount and Membership Type:

Full Time Private Practice	☐	R 1 067.00	Affiliate Members / Medical Officers	☐	R 56.00
First Year Private Practice	☐	R 612.00	Audiologists and Associate Members	☐	R 325.00
Limited Private Practice	☐	R 612.00	Overseas members	☐	R 109.00
Full Time Public Service	☐	R 325.00	Temporary Away Members	☐	R 55.00
Registrars	☐	R 56.00	COSECSA Members (Neighbouring Countries)	☐	R 601.00

Signed at _____ on this _____ day of _____ 20 _____.

_____

(Signature as used for operating on the account)

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

Kindly send it back to email admin@entsociety.co.za