



Unit 16, Northcliff Office Park
203 Beyers Naude Drive
Northcliff
2115

T: 011 340 9000
M: 066 421 6389



YOUR PROFESSIONAL BUSINESS PARTNER

PO Box 2127
Cresta
2118

MEMBERSHIP UPDATE OF DETAILS

TITLE :	MR / MRS / DR / PROF	KNOWN AS:	
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SURNAME:	
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FULL NAMES:	
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Sponsors require us to indicate the following fields for the purposes of BBBEE certification:

ID NUMBER OR PASSPORT NO:	
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IF NOT ID - DATE OF BIRTH:	
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GENDER:	MALE / FEMALE	RACE:	AFRICAN / ASIAN / COLOURED / INDIAN / OTHER / WHITE / UNKOWN
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PHYSICAL ADDRESS IF PRIVATE PRACTICE OR WHICH UNIVERSITY:	CAPE TOWN / FREE STATE /
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KWAZULU NATAL / LIMPOPO / SEFAKO MAKGOTHO / PRETORIA / STELLENBOSCH / WALTER SISULU / WITWATERSRAND

	POSTAL ADDRESS:	
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	CODE:		CODE:	
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PROVINCE:		PROVINCE:	
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PRACTICE NO (BHF),(PCNS):		VAT REGISTRATION NO:	
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HPCSA PROF NO:		CELL NO:	
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PRACTICE TEL NO:		PRACTICE FAX NO:	
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EMAIL ADDRESS: TO RECEIVE COMMUNICATIONS	
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EMAIL ALTERNATIVE: PRACTICE / PERONAL / HOME	
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TYPE OF MEMBERSHIP					
<input type="checkbox"/>	Private Practice	<input type="checkbox"/>	First Year Private Practice	<input type="checkbox"/>	Public Service
<input type="checkbox"/>	Audiologist & Associate Member	<input type="checkbox"/>	Overseas	<input type="checkbox"/>	Registrar
<input type="checkbox"/>	Supernumery Registrar	<input type="checkbox"/>	Medical Officer	<input type="checkbox"/>	Temporary Away Members
<input type="checkbox"/>	Honorary Member				

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 SMS. 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 or fax 011 782-0910 for attention Janette



Unit 16, Northcliff Office Park, 203 Beyers Naude Drive
 Northcliff, Johannesburg, 2115, South Africa
 Tel: (+27)(11) 340 9000, Fax: (+27)(11) 782 0910
 Email: admin@entsociety.co.za or healthman@healthman.co.za
 PO Box 2127, Cresta, Johannesburg, 2118, South Africa
 Registration No.: 96/13338/06

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:	Full Time Private Practice	<input type="checkbox"/> R1031.00	Affiliate Members / Medical Officers	<input type="checkbox"/> R 55.00
	First Year Private Practice	<input type="checkbox"/> R 592.00	Audiologists and Associate Members	<input type="checkbox"/> R 314.00
	Limited Private Practice	<input type="checkbox"/> R 592.00	Overseas members	<input type="checkbox"/> R 106.00
	Full Time Consultant in Public Service	<input type="checkbox"/> R 314.00	Temporary Away Members	<input type="checkbox"/> R 53.00
	Registrars / Supernumery Registrar	<input type="checkbox"/> R 55.00	COSECSA Members (Neighbouring Countries)	<input type="checkbox"/> R 581.00

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.

Please send it back to 066 421 6389 or email admin@entsociety.co.za