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

T: 011 340 9000
M: 066 421 6389
F: 011 782 0910

PO Box 2127
Cresta
2118

# MEMBERSHIP UPDATE OF DETAILS

| | | | |
|---|---|---|---|
| **TITLE:** | MR / MRS / DR / PROF | **KNOWN AS:** | |
| **SURNAME:** | | | |
| **FULL NAMES:** | | | |

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

| | | | |
|---|---|---|---|
| **ID NUMBER OR PASSPORT NO:** | | | |
| **IF NOT ID – DATE OF BIRTH:** | | | |
| **GENDER:** | *MALE / FEMALE* | Equity**:** | *AFRICAN / ASIAN / COLOURED / INDIAN / OTHER / WHITE / UNKOWN* |
| **PHYSICAL ADDRESS IF PRIVATE PRACTICE OR WHICH UNIVERSITY:** | *CAPE TOWN / FREE STATE / KWAZULU NATAL / LIMPOPO / SEFAKO MAKGOTHO / PRETORIA / STELLENBOSCH / WALTER SISULU / WITWATERSRAND* | | |
| | | **POSTAL ADDRESS:** | |
| | | | |
| | | | |
| | **CODE:** | | **CODE:** |
| **PROVINCE:** | | **PROVINCE:** | |
| **PRACTICE NO (BHF),(PCNS):** | | **VAT REGISTRATION NO:** | |
| **HPCSA REGISTRATION NO:** | | **CELL NO:** | |
| **PRACTICE TEL NO:** | | **PRACTICE FAX NO:** | |
| **EMAIL ADRESS:** **TO RECEIVE COMMUNICATIONS** | | | |
| **EMAIL ALTERNATIVE:** **PRACITCE / PERONAL / HOME** | | | |

**TYPE OF MEMBERSHIP**

☐ Private Practice ☐ First Year Private Practice ☐ Public Service ☐ Audiologist & Associate Member ☐ Overseas

☐ Registrar ☐ Supernumery Registrar ☐ Medical Officer ☐ Temporary Away Members ☐ 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 | □ R 977.07 | COSECSA Members (Neighbouring Countries) | □ R 550.92 |
| First Year Private Practice | □ R 560.68 | Audiologists and Associate Members | □ R 298.09 |
| Limited Private Practice | □ R 560.68 | Overseas members | □ R 100.03 |
| Full Time Consultant in Public Service | □ R 298.09 | Temporary Away Members | □ R 49.93 |
| Registrars / Supernumery Registrar | □ R 51.66 | COSECSA Members (Neighbouring Countries) | □ R 550.92 |
| Affiliate Members / Medical Officers | □ R 51.66 | | |

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***