



The Neurological Association of South Africa

C/O SAPPF/FCPSA Office
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Please allow for a maximum of 5-7 working days, from date of receipt for your application to be finalised
MEMBERSHIP APPLICATION

I, the undersigned _____ hereby apply to take up membership in The Neurological Association of South Africa (the Association), which, until further notice, will include automatic additional membership of the South African Private Practice Forum (SAPPF) and the Faculty of Consulting Physicians of South Africa (FCPSA), the object of which is to negotiate with the funders of health care, managed care organisations, health care providers, suppliers of goods and services to members of the Association and with any other relevant parties, with a view to maximising potential synergistic and rationalisation benefits for individual members and the Association. I acknowledge that the Constitution of the Association are available for my inspection and I agree that the NASA Executive may use my medical claims data specifically and exclusively in order to benefit all members of the Association as a group. I acknowledge that Membership of the Association will also entitle me to membership of South African Private Practitioners Forum (SAPPF) and The Faculty of Consulting Physicians of South Africa (FCPSA).

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			
KNOWN AS			
POSTAL ADDRESS			
PRACTICE NAME			
PRACTICE / PHYSICAL ADDRESS			
Sponsors require us to indicate the following fields for the purposes of BBBEE certification:	PRACTICE NO (BHF/ PCNS):	HPCSA REGISTRATION NO:	
ID NUMBER:			
GENDER:			
RACE:			
VAT REGISTRATION NO:	EMAIL ADDRESS:		
PRACTICE TELEPHONE NO:	PRACTICE FAX NO:	CELLULAR NO:	
PRACTICE MANAGER	Full Name:		
	Email Address:		
MEMBERSHIP TYPE	Full Time Private Practice	<input type="checkbox"/> R560.00	
	Public Service	<input type="checkbox"/> R145.00	
	Limited Private Practice -Start-up Private Practice (first two years of Private Practice- please contact NASA offices for a reduced fee)	<input type="checkbox"/> R410.00	
	Registrar	<input type="checkbox"/> Free	
	Overseas	<input type="checkbox"/> Free	
SUB-SPECIALITY OF NEUROLOGY			



The Neurological Association of South Africa

E-mail: neurology@healthman.co.za

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 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.

***Please note: Apart from the first month of your membership and the month of December, your debit orders will be set to go off in the beginning of every month, dependent on weekends and public holidays.**

Payment to (Company name)	HEALTHMAN	
Registered abbreviated company name		
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: <input type="checkbox"/> R560 <input type="checkbox"/> R410 <input type="checkbox"/> R145	

Signed at _____ on this _____ day of _____

(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 0910 or email hillary@healthman.co.za