*[practice letterhead]*

**CONFIRMATION OF REQUIREMENT TO WORK DURING LOCKDOWN**

Our practice has, pursuant to regulation 16 of the Regulations issued under the Disaster Management Act, 2002, on 29 April 2020, identified the person whose name appears on the permit, as part of the “permitted” [i*nclude if applicable:* and/or “essential” – i.e. inside curfew emergency] operations of the practice.

The practice [INSERT PRACTICE NAME] is a [insert type of practice], and the bearer of this letter is part of ensuring the delivery of these services as essential to the provision of health care services.

S/he fulfils the role of [*insert]*.

*[If applicable: His/her professional (HPCSA/ SANC / … ) number is: …]*

*[If applicable: S/he may also need to carry medical supplies and equipment, the transportation of which is part of this essential role.]*

* Our business is situated at [*address*]. The holder of this permit may however need to visit other sites where healthcare is delivered, namely *[insert]*
* The general working hours are: *[insert]*. However, bear in mind that emergency services may need to be rendered at any hour.

We are compliant with all the other regulations required to implement the necessary steps during this state of disaster.

**Kindly allow Mr/Ms/Dr … to travel to and from the above address(es) in order to ensure the delivery of services permitted during level 4 of the disaster**

If there are any queries or concerns, please contact [*insert name, surname and contact details]* who will verify the above, [if applicable: alternatively contact *insert name, surname and contact details]*

Yours sincerely

*[signature]*

*[initials, surname]*

**PERMIT TO PERFORM ESSENTIAL OR PERMITTED SERVICE**

**Regulation 16(2)(b) AND 28(4)**

*Please note that the person to whom the permit is issued must at all times present* a *form of identification together with this permit. If no identification is presented the person to whom the permit is issued will have to return to his or her place of residence during Alert Level-4.*

*I, being the head of the institution, with the below-mentioned details,*

|  |  |
| --- | --- |
| **Surname** |  |
| **Full Names** |  |
| **Identity Nr.** |  |
| **Contact Details** | **Cell Nr.** | **Tel Nr. (w)** | **Tel Nr. (h)** | **Email Address** |
|  |  |  |  |
| **Physical Address of Institution** |  |
| *Herby certify that the below-mentioned official/employee is performing services in my institution:* |
| **Surname** |  |
| **Full Names** |  |
| **Identity Number** |  |
| **Place of Residence of Employee** |  |

Signed at ……………………………….on this the ……….day of …………………2020

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Signature of Head of Institution Official Stamp of Institution