



SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS (SASOP)

Posbus 30252
Wonderboompoort
0033

TEL: 082 838 3932
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EMAIL: sasop@global.co.za

Enquiries: Rika Hamse

(Incorporated under Section 21)
Co Reg No 2007/012757/08

APPLICATION FOR MEMBERSHIP FOR JANUARY TO DECEMBER 2011 SCHEDULE 1 (Clauses 6.4 & 6.5 of Constitution)

I,hereby apply for/renew
..... membership of the South African Society of Psychiatrists.

Attached hereto, marked Annexure A, is a form containing my personal and professional details.

If my application is approved I undertake to:-

- i. At all times further the aims and objectives of the Society;
- ii. Comply with the provisions of the Constitution of the Society; and
- iii. Promptly pay my annual membership fees as determined from time to time by the Society and/or the Subgroup of which I am a member. **(Deadline 31 March 2011)**

Signature

Date

Accounts are payable by:

1. Internet transfer into the South African Society of Psychiatrists Bank Account. Kindly email (sasop@global.co.za) or fax proof of payment to 086 648 5094
2. Direct deposit into the South African Society of Psychiatrists Bank Account.
(Please make sure to fax your deposit slip to the office if you choose this method to 086 648 5094)
3. Sending a cheque to the South African Society of Psychiatrist's Office by post to:
Posbus 30252, Wonderboompoort, 0033

The Account:

Name: South African Society of Psychiatrists (SASOP)
Bank: Standard Bank
Account Number: 072053690
Branch: Blue Route Tokai
Branch Code: 025609

**PLEASE ENSURE TO CLEARLY STATE YOUR PARTICULARS ON ALL TRANSACTIONS
IN ORDER FOR US TO IDENTIFY PAYMENTS**

ANNEXURE A

MEMBERSHIP	MEMBERSHIP FEES: YEARLY SUBSCRIPTION (JANUARY TO DECEMBER)
HONORARY MEMBERS	R 00-00
LIFELONG MEMBERS	R 00-00
RETIRED	R 00-00
ASSOCIATE MEMBERS	R 800-00
REGISTRARS – POST & PRE PRIMARY	R 500-00
FULL TIME PUBLIC SECTOR	R1 200-00
PRIVATE PRACTICE SECTOR	R1 200-00

Please complete the information below and fax this form with proof of payment to RIKA HARMSE on 086 648 5094

TITLE				
FIRST NAMES				
LAST NAME				
NICK NAME				
HPCSA NO.				
SAMA MEMBERSHIP NO. (if applicable)				
ID				
POSTAL ADDRESS				
PHYSICAL ADDRESS OF PRACTICE				
WORK PHONE				
FAX				
HOME PHONE				
CELL PHONE				
BLEEP				
E-MAIL				
SECRETARY'S NAME				
SPOUSE NAME				
MEMBERSHIP (PLEASE TICK BOX AND SUBMIT REMITTANCE ACCORDINGLY)	HONORARY MEMBER	<input type="checkbox"/>	LIFE MEMBER	<input type="checkbox"/>
	FULL MEMBER	<input type="checkbox"/>	ASSOCIATE MEMBER	<input type="checkbox"/>
	REGISTRAR	<input type="checkbox"/>	RETIRED	<input type="checkbox"/>
REGISTRARSHIP:	STARTING DATE	<input type="text"/>	ENDING DATE	<input type="text"/>
SUBGROUP				
SUBGROUP PORTFOLIO				
PRIVATE PRACTICE	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	
HOSPITAL PRACTICE	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	
MIXED PRACTICE	<input type="checkbox"/>	HOSPITALS	<input type="checkbox"/>	
FIELD OF INTEREST				
HOBBIES				
DO YOU HAVE ACCESS TO THE INTERNET? (PLEASE TICK APPROPRIATE BOX)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
DO YOU HAVE ACCESS TO E-MAIL? (PLEASE TICK APPROPRIATE BOX)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>