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

Tel: 011 340 9000
Fax: 011 782 0270

PO Box 2127
Cresta
2118

MEMBERSHIP APPLICATION

I, the undersigned ____ hereby apply to take up membership in the Psychiatry Management Group Limited (the Company), the object of which is to negotiate with the funders of health care, managed care organisations, other health care providers and the suppliers of goods and services to the respective members of the Company, with a view to maximising the potential synergistic and rationalisation benefits for each member. I acknowledge that the Articles of Association of the Company are available for my inspection and I agree that the board may use the pharmaceutical/ claims data as a means of enhancing the group.

I acknowledge that Membership of the Company will also entitle me to membership of South African Private Practitioners Forum (SAPPF) & South African Society of Psychiatrists (SASOP).

SIGNED at_______________________________ this __________________day of ________________________2012.

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		
POSTAL ADDRESS		Code:
PRACTICE / PHYSICAL ADDRESS		
PROVINCE		Code:
IDENTITY NUMBER	PRACTICE NUMBER (BHF),(PCNS)	HPCSA REGISTRATION NUMBER

VAT REGISTRATION NUMBER	EMAIL ADDRESS

PRACTICE TELEPHONE NO.	PRACTICE FAX NO.	CELLULAR NO.
MEMBERSHIP TYPE	Fulltime Private Practice ☐ Limited Private Practice ☐ Public Service & Very Limited Private Practice ☐	
SUB-SPECIALTY		

Please ensure you complete the membership application page AND the ACB authority page

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ACB AUTHORITY

I hereby request that the company make withdrawals from my bank account on the date(s) specified below or at any other time stipulated in the event of the transfer not being made.

NAME OF ACCOUNT HOLDER	
PRACTICE NO.	
Banking Details	
ACCOUNT TYPE	Current ☐ Cheque ☐ Savings ☐
NAME OF BANK	
BRANCH	
ACCOUNT NO.	
BANK CLEARANCE CODE *(top right corner of cheque)*	
MONTHLY AMOUNT *(Incl. VAT)*	
To be Charged from:	_________/_________/_________

Fee Structure:

1. Full Time Private Practice – R 1000 (Inclusive VAT) per month
2. Limited Private Practice – R 500 (Inclusive VAT) per month
3. Public Service & Very Limited Private Practice – R 300 (Inclusive VAT) per month

The company will charge my account on the 1st (first) and on the same day of each month thereafter. It is hereby agreed that this authority will remain in force until cancelled in writing. Annual adjustments will be notified 60 days in advance.

SIGNED AT: ______________________ on ________________________ 2012.

SIGNATURE: ______________________________

Please attach a cancelled cheque

Please ensure you complete the membership application page AND the ACB authority page

Please Fax Back to 011 782 0270