



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

Tel: 011 340 9000
Fax: 011 782 0270

PO Box 2127
Cresta
2118

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.	
<u>Banking Details</u>	
ACCOUNT TYPE	Current <input type="checkbox"/> Cheque <input type="checkbox"/> Savings <input type="checkbox"/>
NAME OF BANK	
BRANCH	
ACCOUNT NO.	
BANK CLEARANCE CODE <i>(top right corner of cheque)</i>	
MONTHLY AMOUNT <i>(Incl. VAT)</i>	
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**