PsychMg
Psychiatry Management Group

Tel: 011 340 9000
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Request Form for Limited Private Practice Category

I **(Name and Surname)** ____, hereby confirm that the below information is correct and true. Should any information change, I acknowledge that it is my responsibility to notify PsychMg accordingly.

SIGNED at___________________________ this ________________day of _____________________20___.

Signature: _____________________________

Please note that the Limited Private Practice category is subject to approval by the PsychMg board of Directors and will be annually reviewed. Once annually, membership will be automatically updated to the Fulltime Private Practice category. Should you wish to reapply, please send an updated request form.

- ☐ Existing SASOP Member
- ☐ Existing PsychMg Member
- ☐ New application for PsychMg Membership
- ☐ Limited Private Practice R1172/month

Name and Surname of Psychiatrist	
MP Number	
Email Address	
Telephone/ cell number	
Indicate first year of private practice	
Current place/s of work (please include both public and private, if applicable) *If applicable, please attach your RWOPS certificate	1
	2
	3
<u>Working hours</u> 1. Public Work per week	
2. Private Work per week	
Number of working days a week	

*Refer to BoD requirements for approval