



SASOP MEMBERSHIP APPLICATION/UPDATE FORM

Please allow for a maximum of 5-7 working days, from date of receipt, for your application to be finalised.

I, the undersigned _____ hereby apply to take up membership in the South African Society of Psychiatrists the objects of which are to promote, maintain and protect the honour and interests of members, the discipline of Psychiatry as a medical specialty and to serve the community. I acknowledge that the Memorandum of Incorporation of the Company are available for my inspection.

SIGNED at _____ this _____ day of _____ 20__

. Signature: _____

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.

How did you hear about us?

TITLE					
SURNAME					
FULL NAMES					
KNOWN AS NAME	Sponsors require us to indicate the following fields for the purposes of BBBEE certification:				
	ID Number:				
	Gender:				
	Race:				
RESIDENTIAL ADDRESS (Required)					Code:
PRACTICE ADDRESS					Code:
PRACTICE NAME					
PRACTICE TELEPHONE NO.	INCOME TAX NO: (Required)		CELLULAR NO.		
EMAIL ADDRESS	Sub-Group				
	Eastern Cape		Limpopo		Western Cape
	Free State		Northern Gauteng		North West
	Kwa-Zulu Natal		Southern Gauteng		
VAT REGISTRATION NUMBER	PRACTICE NUMBER (BHF)(PCNS)		HPCSA REGISTRATION NUMBER		

Membership Type (Please circle)	Full Member Private Practice (R1340.00/ m) Full Member Limited Private Practice (R1340.00/ m) Associate Member (R275.00/ m) Full Member Public Service (R552.00/ m) Pensioner, International, Life & Honorary (Free)	REGISTRAR: 1st year Registrar (R36.00/ month) 2nd year Registrar (R72.00/ month) 3rd year Registrar (R108.00/ month) 4th year Registrar (R144.00/ month)
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Written Authority and Mandate for Debit Payment Instructions

This signed Authority and Mandate refers to our contract dated _____ (“the Agreement”).
I/We hereby authorise you to issue and deliver payment instructions to your Banker for collection against my/our above-mentioned account at my/our above-mentioned Bank (or any other bank or branch to which I/we may transfer my/our account) on condition that the sum of such payment instructions will never exceed my/our obligations as agreed to in the Agreement and commencing on _____ and continuing until this Authority and Mandate is terminated by me/us by giving you notice in writing of not less than 20 ordinary working days, and sent by prepaid registered post or delivered to your address as indicated above. The individual payment instructions so authorised to be issued must be issued and delivered monthly.
In the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day. Payment Instructions due in December may be debited against my account on _____/NA _____(date).

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I also understand that details of each withdrawal will be printed on my bank statement. Such must contain a reference number which is a practice number, which must be included in the said payment instruction and if provided to me should enable me to identify the Agreement.

Mandate: I/We acknowledge that all payment instructions issued by you shall be treated by my/our below-mentioned Bank as if the instructions have been issued by me/us personally.

Cancellation: I/We agree that although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to you.

Assignment: I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.

You will be notified within 30 days of the next debit order payment of any fee increases for your membership.

Your debit order will then automatically be adjusted to reflect these increases.

Payment to (Company name) Registered abbreviated company name	South African Society of Psychiatrists SASOP
Name of account holder	
Address of account holder	
Practice number	
Banking details	
Name of Bank	Type of Account
Branch Name	Branch code
Account number	Monthly amount: ☐ R1340.00 ☐ R552.00 ☐ R275.00 ☐ R144.00 ☐ R108.00 ☐ R72.00 ☐ R36.00

Signed at _____ on this _____ day of _____

(Signature as used for operating on the account)

Please attach a cancelled cheque/ proof of banking details. Please ensure you complete the membership application form AND the written authority for debit order payment instructions.

Email reception@healthman.co.za

COMPULSORY SASOP MEMBERSHIP NOMINATION and SIG FORM

To be accompanied by SASOP Membership Application Form.

Section A: This section only applies to new members or past members re-joining.

Proposer Psychiatrist (SASOP Member)

Initials and Surname	
MP Number	
Mobile Number	
Qualification	

Signed atOn this.....day of.....

Secondar Psychiatrist (SASOP Member)

Initials and Surname	
MP Number	
Mobile Number	
Qualification	

Signed atOn this.....day of.....

Section B: This section is to be completed by all.

Special Interest Groups (SIG's):

SIG's have been constituted in terms of sub-specialty areas and constitute a formal committee that will hold meetings and drive projects. Please indicate below if you are or would like to participate as a member or receive communications for these SIG's.

ADHD		African Psychiatry Division	
Biological		Cellular & Molecular	
Child & Adolescent Psychiatry		Early Career & Registrar Division	
Forensic Psychiatry		Interventional Psychiatry	
Neuropsychiatry		Old Age Psychiatry	
Philosophy of Psychiatry		Psychotherapy	
Spirituality & Psychiatry		Substance Use & Addiction	
Women's Mental Health			

Special Interests (SI):

Please indicate your special interests below. You will receive communication based on your selection. Any searches (by the public) containing your special interest will identify you as a potential provider. You may select more than one option.

Mental Health – Dementia, Depression, Schizophrenia		Psychiatric Impairment Assessment	
PTSD (Traumatic Stress)			

STATEMENT OF CONSENT TO DATA PROCESSING

(In terms of the provisions of the Protection of Personal Information Act)

1. I, _____ (full names of Society/Group member), ID number _____ (“the member”) hereby grant **my consent to** _____ (“Society/Group”) and their appointed *processor* to process my personal data for the purpose of any or all of the undermentioned actions, being the legitimate reasons *for processing and/or using my personal data*;
2. I accept that my personal information will only be utilized for the purpose it was collected, that the information will only be retained for as long as is necessary and required by law, and that I have the right to view such information at any time, as well as request correction or deletion of my personal Information held by the Society/Group;
3. I the undersigned furthermore warrant that such information is accurate, relevant, up to date and complete and I undertake to advise Society/Group in writing of any material change of such information.
4. I am aware that I may withdraw my consent at any time by using the relevant Data Subject Consent Withdrawal Form.
5. I can opt out of receiving communications. However, communications regarding my profile and account cannot be opted out of.

Signed by the member: _____

Date: _____

Authorised actions:

- To collect and have access to my personal information.
- To process my personal information (both terms as defined in the Protection of Personal Information Act, Act 4 of 2013 [“POPI”]), which processing includes amongst others the ‘collecting, storing and dissemination’ of my personal information (as defined in POPI) for the purpose of rendering services to me;
- Share my personal information with third parties who provide services ancillary to the services I have obtained and will obtain from the Society/Group;
- To allow my Society/Group’s administrator, HealthMan, and its employees and contractors access to my personal information for the purposes of rendering services to me.
- To use my personal information to communicate with me in person/via telephone/email/video call/fax/WhatsApp/any form of social media.