MEMBERSHIP APPLICATION FORM

Please fax the completed application form to 086 559 1016 or e-mail it to info@sahasa.co.za

MEMBER'S NAME

SAHASA: PO Box 611, Strand, 7139
Tel: 021 850 8999
Fax: 086 559 1016
Website: www.sahasa.co.za

In addition to the Constitution of SAHASA the Member agrees to be bound to the following:

1 That you are aware that SAHSA offers tariff negotiations and contract management services on behalf of its Members and that you mandate and opt into such service by joining.

2 The Members undertakes to abide by the agreements made between SAHASA and the Funders for each applicable year.

3 The Member undertakes not to negotiate directly with any Funder without prior written consent of SAHSA.

4 Membership fees are payable monthly in advance, preferably via debit order.

5 The Member undertakes to purchase a membership certificate from SAHASA that will be displayed in their reception area.

6 The Member undertakes to remove the membership certificate within one month after resignation from SAHASA or termination of their SAHASA membership.

7 If a Member resigns within the course of the year, the full years membership will remain payable.

8 In the event of any non-disclosed shareholder purchasing shares in the Member hospital, such sale will be disclosed forthwith to SAHASA. Continued membership of SAHASA will be subject to board approval.

9 By signature hereof the Member binds himself/herself personally as well his/her hospital/clinic to the provisions of the Constitution, Rules and Procedures of SAHASA.

10 The Member hereby warrants that none of the acute hospital groups, i.e. Life Health Care, Mediclinic or Netcare, holds any shares in his/her hospitals.

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Signature of Member's Representative

Additional Requirements:

- Proof of contractual ability must be submitted
- Any amendments to the application must be initialled by the applicant
- Payment by means of cash or cheque by mail is done at the risk of the dispatcher
- A receipt for payment received in cash or cheque will be issued by SAHASA
- The applicant has the onus to ensure that the application form together with the payment is made in the correct manner to the offices of the administrators of SAHASA

Members' duly authorised representative's details			
Surname:			
Title:			
Name(s):			
Identity Number:			
Telephone Number:			
Name of entity/person applying:			
Majority Shareholder:			
Postal Address:			
Type of Payment	Direct Deposit	EFT	Cheque
E-mail Address:			
Members' Information			
Members' Registered Name:			
Registration Number:			
Practice Number:			
VAT Number:			
Telephone Number:			
Fax Number:			
E-mail Address:			
Website Address:			
Physical Address			
Postal Address			
Province:			
Number of Registered Beds (Please attach certificate from Department of Health):			
Member's Profile			
Sub-Acute Discipline	**BHF Practice Code**		
General Sub-Acute	49001		
Psychiatry	49002		
Physical Rehabilitation	49003		
All Services	49004		
Postnatal	49005		
Psychiatry/Postnatal	49006		
Physical Rehabilitation/Postnatal	49007		
Specialised Psychiatry	49008		
Discipline	**Y/N**		
Occupational Therapy			
Physiotherapy			
Speech Therapy			
Social Worker			

Contact Information	
Hospital Manager	
Name:	
Telephone Number:	
E-mail Address:	
Secretary's Name:	
Secretary's E-mail Address:	
Financial Manager	
Name:	
Telephone Number:	
E-mail Address:	
Postal Address for SAHASA Invoice:	
Nursing Services Manager	
Name:	
Telephone Number:	
E-mail Address:	
Case Manager	
Name:	
Telephone Number:	
E-mail Address:	
Banking Information	
Member's Banking Detail	
Bank:	
Branch:	
Branch Code:	
Account Number:	
Type of Account:	

The applicant hereby warrants that all information provided is accurate and complete.

SIGNED at …….. on this …… day of …….. 20 ……..

_____	_____	_____
Member Signature	SAHASA Chairman Signature	Witness Signature
_____	_____	_____
Print Name	Print Name	Print Name