

THE DAY HOSPITAL ASSOCIATION

MEMBERSHIP APPLICATION FORM

MEMBER NAME

Please return this form after completion to: admin@dhasa.co.za

Day Hospital Association - Address	506 Jochemus Avenue, Erasmuskloof
Telephone Number:	012-942-9517
Fax Number:	086-517-1005
Website:	<a href="http://www.dhasa.co.za">www.dhasa.co.za</a>
Yearly Membership Fee:	<b>January 2017: R960 per bed, per year. Payable monthly or annually.</b>

**AGREEMENT:**

1. Membership Fees are payable monthly, quarterly or yearly in advance.
2. If the member resigns within the course of the year, the full membership fee will remain payable.
2. All members of the Day Hospital Association are bound to be members of NHN.
4. By signature hereof the member binds himself personally as well as his day clinic, to the provisions of the Memorandum of Incorporation, Rules and Procedures of the Day Clinic Association.
  - All amendments to the application form must be initialled by the applicant.
  - The member hereby warrants that none of the bigger hospital groups hold shares in your clinic.

Initial: Member \_\_\_\_\_ / Initial: DSA \_\_\_\_\_ / Initial Witness: \_\_\_\_\_ / Date: \_\_\_\_\_

### Members duly authorised representative's details

Surname:			
Title:			
First Name:			
Identity Number:			
Main Shareholder:			
Postal Address:			
Type of Payment:	Direct Deposit	Cheque	EFT
E-mail address:			
Contact Number:			

### Members Information

Registered Name:			
Practice Number:			
VAT Number:			
Registration Number:			
Telephone Number Office:			
Fax Number:			
E-mail address:			
Website Address:			
Postal Address:			
Physical Address:			
Number of registered beds:			
Number of registered theatres:			

### Disciplines

DESCRIPTION	MARK WITH A "X"
Dermatology	
Dentistry	
Ear,Nose and Throat	
General Surgery	
Gynaecology	
Ophthalmology	
Oral Surgery	
Orthopaedic	
Urology	
Cosmetic Surgery	
Maxillo Facial	
Other	

Initial: Member \_\_\_\_\_ / Initial: DSA \_\_\_\_\_ / Initial Witness: \_\_\_\_\_ / Date: \_\_\_\_\_

### Contract Information

	Name & Surname	E-Mail Address	Contact Number
Hospital Manager			
Financial Manager			
Admin Manager			
Nurse Manager			
Case Manager			

### Members Banking Details

Bank:	
Branch:	
Branch Code:	
Account Number:	
Type of Account:	

### DHA Banking Details

Bank:	FIRST NATIONAL BANK
Branch:	LYNNWOOD
Branch Code:	254-005
Account Number:	5881-003-6228
Type of Account:	CURRENT

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ 2014.

Member:	
Signature:	
Print Name:	
Witness	

Day Clinic Association	
Signature:	
Print Name:	
Witness	

Initial: Member \_\_\_\_\_ / Initial: DSA \_\_\_\_\_ / Initial Witness: \_\_\_\_\_ / Date: \_\_\_\_\_