I1. SASOHN MEMBERSHIP APPLICATION FORM

Only complete this form if you have never been a SASOHN member before. Please fax or email to the National Office.

**Please Note:** By completing this form you consent in terms of the Protection of Personal Information Act (POPI) to your personal information being obtained, utilized, and stored by SASOHN data systems.

(Failure to complete this form CLEARLY and in full will result in you not receiving correspondence from SASOHN)

# PERSONAL DETAILS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TITLE** |  | **SASOHN NO** | **OFFICE USE ONLY** | **SANC REG NO** |  |
| **GIVEN NAMES:** |  | **PREFERRED NAME** |  |
| **SURNAME** |  | **PREVIOUS / OTHER SURNAME (if applicable)** |  |
| **CELL NUMBER** |  | **WORK TEL NUMER** |  |
| **ID NO** |  | **DATE OF BIRTH** |  |
| **ETHNICITY** | [ ]  African  | [ ]  Caucasian | [ ]  Coloured | [ ]  Indian | [ ]  Asian | **GENDER** | [ ]  Male  | [ ]  Female |
| **PREFERRED EMAIL ADDRESS** |  | **OTHER EMAIL ADDRESS** |  |
| **PHYSICAL ADDRESS/POSTAL ADDRESS (NB – all order deliveries i.e. book orders, will be sent to this address)** |
|  |
|  | **POSTAL CODE** |  |
| **QUALIFICATONS** |  |
|  |
| **INSTITUTION WHERE HIGHEST QUALIFICATION WAS OBTAINED** |  |
| **PLEASE TICK** | [ ]  **DIPLOMA** | [ ]  **DEGREE** | [ ]  **MASTERS** | [ ]  **PHD** | [ ]  **OTHER** |

# EMPLOYMENT DETAILS (Please provide the correct company name and billing information for the invoice)

|  |  |  |  |
| --- | --- | --- | --- |
| **COMPANY FULL NAME** |  | **COMPANY VAT NO** |  |
| **POSTAL ADDRESS** |  |
|  | **POSTAL CODE** |  |
| **PROFESSION** | [ ]  Registered Nurse (RN)[ ]  Enrolled Nurse (EN) / Staff Nurse[ ]  Enrolled Nursing Assistant (ENA) / Auxiliary Nurse[ ]  Professional Nurse (PN)[ ]  Occupational Health Nurse Practitioner (OHNP)[ ]  Educator[ ]  Occupational Medical Practitioner (OMP)[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **TYPE OF INDUSTRY** | [ ] Healthcare & Medical[ ] Corporate & Commercial[ ] Industrial & Manufacturing[ ] Mining & Energy[ ] Agriculture & Food Production[ ] Construction & Engineering[ ] Transport & Logistics[ ] Retail & Warehousing[ ] Education & Academia[ ] Security & Defense[ ] Hospitality & Tourism[ ] Technology & Telecommunications[ ] Government & Parastatals[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# SASOHN REGION (Please indicate the region of your choice from the list below)

# [ ]  EASTERN CAPE [ ]  GAUTENG CENTRAL [ ]  KZN COASTAL [ ]  KZN INLAND [ ]  MPUMALANGA [ ]  NORTHERN NATAL – DISCUSSION GROUP [ ]  PRETORIA [ ]  VAAL

# [ ]  WEST RAND [ ]  WESTERN CAPE [ ]  INTERNATIONAL MEMBER

# MEMBERSHIP TYPE

[ ]  **FULL MEMBER** [ ]  **INTERNATIONAL MEMBER** [ ]  **RETIRED MEMBER** [ ]  **AFFILIATE MEMBER**

**I am applying as an affiliate member because of**

* 1. **my profession - please specify.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. **being an international colleague - please specify.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **and/or**
	3. **being affiliated with another professional organisation - please specify.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*NB: Affiliate, International and Retired Members DO NOT qualify for Indemnity. This also applies to members who are not employed in Occupational Health.*

|  |  |  |
| --- | --- | --- |
|  |  | Click or tap to enter a date. |
| **SIGNATURE** |  | **DATE** |

***By signing this form electronically, you acknowledge and agree that your electronic signature is legally binding and has the same validity and enforceability as your handwritten signature. You further confirm that all the information provided is accurate and truthful to the best of your knowledge. Your electronic signature signifies your acceptance of the terms and conditions of membership as outlined by SASOHN.***

***If you wish to stop your membership at any time, SASOHN National Office must be notified in writing otherwise you will be liable to pay outstanding fees.***

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| --- |
| **Please attach a certified copy (not older than 3 months) of the following documents:** |
| Certified copy of Identity Document/Passport |[ ]
| Certified copy of Qualification/Occupational Health Qualification (Certificate/Diploma) |[ ]
| SANC Receipt of Current Year (for registered nurses only) |[ ]