**I2. CHANGE OF DETAILS**

**To be completed upon change of employment or any personal details**

**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 in full and email to the National Office will result in you not receiving correspondence)**

1. **PERSONAL DETAILS**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TITLE** |  | **SASOHN NO** | |  | | **SANC REG NO** | | |  | |
| **GIVEN NAMES** |  | | | | | **PREFERRED NAME** | | |  | |
| **SURNAME** |  | | | | | **PREVIOUS / OTHER SURNAME (if applicable)** | | |  | |
| **ID NO** |  | | | | | **DATE OF BIRTH** | | |  | |
| **CELL NUMBER** |  | | | | | **WORK TEL NUMER** | | |  | |
| **ETHNICITY** | African  Caucasian  Colored  Indian  Asian | | | | | **GENDER** | | | Male  Female | |
| **PREFERRED EMAIL ADDRESS** |  | | | | | **OTHER EMAIL ADDRESS** | | |  | |
| **PHYSICAL ADDRESS/POSTAL ADDRESS (Note: all order deliveries e.g. book orders etc. will be sent to this address)** | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | **POSTAL CODE** | | |  | | |
| **QUALIFICATONS** |  | | | | | | | | | |
|  | | | | | | | | | |
| NAME OF INSTITUTION WHERE HIGHEST STUDY COMPLETED |  | | | | | | | | | |
| **PLEASE TICK** | **DIPLOMA** | | **DEGREE** | | | **MASTERS** | **PHD** | | | **OTHER** |

1. **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 & Defence  Hospitality & Tourism  Technology & Telecommunications  Government & Parastatals  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **SASOHN REGION (Please indicate the region of your choice from the list below ONLY)**

**EASTERN CAPE  GAUTENG CENTRAL  KZN COASTAL  KZN INLAND  MPUMALANGA** **NORTHERN NATAL – DISCUSSION GROUP  PRETORIA  VAAL  WEST RAND  WESTERN CAPE**

1. **MEMBERSHIP TYPE**

NB: Affiliate and International members DO NOT qualify for Indemnity. This also applies to members not employed in Occupational Health.

**FULL MEMBER**  **AFFILIATE MEMBER**  **HONORARY LIFE MEMBER**  **INTERNATIONAL MEMBER**   **RETIRED MEMBER (>60 to 64)  RETIRED MEMBER (>65)**

|  |
| --- |
| **Please attach a copy of the following documents:** SANC Receipt of Current Year (only for registered nurses) |

*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*

|  |  |  |
| --- | --- | --- |
|  |  | 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***