

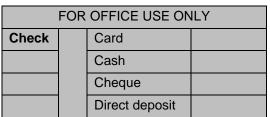
Application for registration in the category Community Service

 This form is to be used <u>only</u> by applicants who trained at a South African Nursing Education Institution;
 Please complete <u>all required information</u> using a ballpoint pen and <u>print</u> clearly. Instructions:

Personai Details	j.																		
S. A. Nursing Council Reference Number										NO	TE:								
Title:	(tick ✓ one box)	Dr		Mr		Ms		Pro	f	If you have changed any of the detail									
Surname:							appearing in your identity of passport since registering a												
Given Names (in full):										and	l if you	ı have	e not a	alread	dy dor	ne so	, you		
Maiden Name (if appli	icable):									- mu sub	st ostanti	subi ating			tified e toge		oroof with		
Sex:	(tick ✓ one box)	Female Male					е			this application.									
Date of Birth:	(yyyy-mm-dd)	Υ	Υ	Υ	Υ	-	M	M	-	D	D								
South African Identity	Number:																		
OR alternatively, for	those applicants who do	not ha	ve a	South	1 Afric	an Id	entity	Num	ber:										
 Passport Number 	er:																		
- Passport Country	y of Issue:										•								
- Passport Expiry	Date (yyyy-mm-dd):	Υ	Υ	Υ	Υ	_	M	M	-	D	D								
							NOTE: Enter your home postal address – to be recorded in the register.												
							Institution.												
							Do not use the address of the health establishment												
Postal Code:							where you will be performing community service.												
Posidential Add	ress (if different):																		
Residential Addi	ess (ii dillerelli).						NO	TE.	Enton		homo	rooio	lontio	l addr					
							NOTE: Enter your home residential address here only if it is different to your postal address.												
							<u>Do not</u> use the address of your nursing education institution.												
								<u>Do not</u> use the address of the health establishment											
Postal Code:							wh	ere y	ou wil	l be p	erforn	ning c	comm	unity	servi	ce.			
Address to whic	h your registratio	n ce	rtifi	cate	sho	ould	be	pos	ted	(if d	liffer	ent):						
							NOTE: Enter the postal address to which your registration certificate and/or any correspondence in connection with this application should be sent.												
									ress o gister		s ente	red h	ere w	ill <u>not</u>	be re	ecorde	ed		
Postal Code:			T	T	T		"''	, 10 16	910101	•									

Telephone Number (home):												
Telephone Number (work):												
Cellular phone Number:												
Fax Number:												
E-mail Address:		,						•	'			
Qualification Details:												
Nursing Education Institution Number:												
Name of Nursing Education Institution:					•				'			
Name of Course completed: Course leading to Registration as a Nurs	se (G	enera	I, Ps	ychiat	ric an	d Cor	nmun	ity) ar	nd Mic	dwife		
Completion Date: (yyyy	-mm-	dd)	Υ	Υ	Υ	Υ	-	M	M	-	D	D
Name of Qualification:												
Date of Qualification issued/ to be issued: (yyyyy-	-mm-	dd)	Υ	Υ	Υ	Υ	-	M	M	-	D	D
Details of Community Service:												
Name of Health Establishment (where Community Service will be performed):												
Name of Town/ City:												
Province:												
Date of commencement of Community Service: (yyyyy-	-mm-	dd)	Υ	Υ	Υ	Υ	-	M	M	-	D	D
Signed by Applicant:												
I certify that the information provided in this application is true and co	rrect.											
Signature:												
Date: (yyyy-mm-dd) Y Y Y - M M -	D	D										
Declaration by Head of Nursing Education Institu	tion	1:										
 I declare that: I have checked the application for both content and completenes The applicant has completed and met all the requirements of the The applicant has been/ will be issued the above qualification by institution on the date indicated; and I may be held personally responsible for any errors or omissions this application. 	cour the a	above										
Signature:												
Print Name:	1	1	1									
S. A. Nursing Council Reference Number:	4											
Date: (yyyy-mm-dd) Y Y Y - M	M	-	D	D	<u>Sta</u>	mp o	f Nurs	ing E	<u>ducati</u>	ion In	<u>stituti</u>	<u>on</u>
PLEASE NOTE that when this form is submitted to the I	ing	FOR OFFICE USE ON										
Council it must be accompanied by the following items:	İ	Che	ck	T	Card							
	ŀ			-	<u> </u>							

- 1. <u>Certified</u> copy of applicant's identity document or passport;
- 2. Official transcript of training for the above-mentioned course;
- 3. Registration fee of **R400-00**(*) (including VAT) or proof of payment thereof into the SA Nursing Council bank account. Use SANC number followed immediately by **REGFPRA** as reference.





Cecilia Makiwane Building, 602 Pretorius Street, Arcadia, Pretoria 0083 Private Bag X132, Pretoria 0001, Republic of South Africa



Tel: 012 420 1000 Fax: 012 343 5400 SANC Fraud Hotline: 0800 20 12 16



SANC 4-22 rev 7 (2020.01.01) website: www.sanc.co.za



The above-mentioned fee applies from 01 January 2020.