South African Nursing Council
Regulating nursing, advocating for the public

Community Service Completion Report

Instructions:

1. *Please complete all required information using a ballpoint pen.*
2. *Print all information clearly.*
3. *All information must be supplied – this will ensure that details which may have changed during the period of Community Service are correctly updated in the register.*

Personal Details of Practitioner:

S. A. Nursing Council Reference Number																
Title: (*tick ✓ one box*)	Dr.		Mr.		Ms.		Miss									
Surname:																
Given Names (in full):																
Maiden Name (if applicable):																
Gender: (*tick ✓ one box*)	Female				Male											
Date of Birth: *(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D						
South African Identity Number:																
OR *alternatively, for those applicants who do not have a South African Identity Number:*																
– Passport Number																
– Passport Country of Issue																
– Passport Expiry Date (yyyy-mm-dd)	Y	Y	Y	Y	–	M	M	–	D	D						

NOTE:
If you have changed any of the details appearing in your identity document or passport since registering as a student and if you have not already done so, you must submit certified proof substantiating the change together with this application.

Postal Address:

	***NOTE**: Enter your home postal address – to be recorded in the register.* *Do not use the address of the health establishment where you performed Community Service.*
Postal Code:	

(2024.01.01)

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

website: www.sanc.co.za

Residential Address (<u>if different</u>):

					***<u>NOTE</u>**: Enter your home residential address here <u>only</u> if it is different to your postal address. <u>Do not</u> use the address of the health establishment where you performed Community Service.*
Postal Code:					

Address to which your registration certificate should be posted (<u>if different</u>):

					***<u>NOTE</u>**: Enter the postal address to which your registration certificate and/or any correspondence in connection with your registration should be sent. The address details entered here will <u>not</u> be recorded in the register.*
Postal Code:					

Contact Details:

Telephone Number (home):													
Telephone Number (work):													
Cellular phone Number:													
Fax Number:													
E-mail Address:													

Details of Community Service:

Name of Health Establishment (hospital/Clinic): (where Community Service was completed)											
Name of Town/ City:											
Province:											
Date of commencement of Community Service:	*(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D
Date of completion of Community Service:	(yyyy-mm-dd)	Y	Y	Y	Y	–	M	M	–	D	D

Signed by Practitioner:

I certify that the information provided in this report is true and correct.
<u>Signature</u>:

Date: *(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D

1. Registration fees of **R1 680-00**(*) (including VAT) or proof of payment thereof into the SA Nursing Council bank account. Use SANC number followed immediately by **REGFPRA** as reference.

For office use	
Cash	
Direct deposit	

(*) R1 1680 equals R840-00 for registration as a Nurse plus R840-00 for registration as Midwife.

The above-mentioned fee applies from **01 January 2024**.

Signed by Head of Public Health Establishment:

I certify that the above-mentioned practitioner has completed the required 12-month period of Community Service at this Public Health Establishment, starting on the commencement date and ending on the completion date indicated above.										
Signature:										
Print Name:										
Date: *(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D

Stamp of Public Health Establishment

Signed by Provincial Coordinator for Community Service:

I certify that the above named practitioner has completed the 12-month period of Community Service required in terms of the regulations, and is now eligible to be registered as Professional Nurse.										
Signature:										
Print Name:										
Date: *(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D