



# OSSA

Ophthalmological Society of South Africa

Unit 16 Northcliff Office Park  
203 Beyers Naude Drive  
Northcliff, 2115

Tel: 011 340 9000  
Fax: 011 782 0270



PO Box 2127  
Cresta  
2118

## APPLICATION TO SUBSCRIBE FOR SHARES

I, the undersigned \_\_\_\_\_ hereby apply to take up shares in the OPHTHALMOLOGY MANAGEMENT GROUP LIMITED (the Company), the objects of which are to negotiate with the funders of health care, managed care organisations, other health care providers and the suppliers of goods and services to the respective shareholders of the Company, with a view to maximising the potential synergistic and rationalisation benefits for each shareholder. I acknowledge that the Articles of Association of the Company are available for my inspection.

I acknowledge that Membership of the Company will also entitle me to membership of Ophthalmologic Society of South Africa (OSSA) and South African Private Practitioners Forum (SAPPF).

SIGNED at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 2011.

**Costs:**

1. R1 for the purchase of 1 (one) share in the company.
2. R 1600 Including VAT per month for management fees payable to OMG by debit order
3. If you wish to apply for a reduced fee please contact us at the HealthMan offices.

**NOTE:**

*Membership information, to be completed by the applicant (or each partner in the event of a group practice). The information below is necessary in order to prepare a complete members database. Please complete in full. Retain a copy for your records. The majority of communications is by e-mail and sms notifications.*

TIILE		
SURNAME		
FIRST NAMES		
POSTAL ADDRESS		Code:
PRACTICE / PHYSICAL ADDRESS		
PROVINCE		Code:
IDENTITY NUMBER	PRACTICE NUMBER (BHF),(PCNS)	HPCSA REGISTRATION NUMBER
VAT REGISTRATION NUMBER		EMAIL ADDRESS
PRACTICE TELEPHONE NO.	PRACTICE FAX NO.	CELLULAR NO.
MEMBERSHIP TYPE	Fulltime Private Practice <input type="checkbox"/> Other <input type="checkbox"/>	

**Please ensure you complete the membership application page AND the ACB authority page  
Please Fax Back to 011 782 0270**



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## ACB AUTHORITY

I hereby request that the Company make withdrawals from my bank account on the date(s) specified below or at any other time stipulated in the event of the transfer not being made.

NAME OF ACCOUNT HOLDER	
PRACTICE NO.	
<b>Banking Details</b>	
ACCOUNT TYPE	Current <input type="checkbox"/> Cheque <input type="checkbox"/> Savings <input type="checkbox"/>
NAME OF BANK	
BRANCH	
ACCOUNT NO.	
BANK CLEARANCE CODE <i>(top right corner of cheque)</i>	
MONTHLY AMOUNT <i>(Incl. VAT)</i>	R 1600.00 (Incl. VAT)
To be Charged from:	_____/_____/_____

### Fee Structure:

1. Full Time Private Practice – R1600.00 (Incl. VAT) per month
2. If you wish to apply for a reduced fee please contact us at the HealthMan offices.

The company will charge my account on the 1st (first) and on the same day of each month thereafter. It is hereby agreed that this authority will remain in force until cancelled in writing. Annual adjustments will be notified 60 days in advance.

SIGNED AT: \_\_\_\_\_ on \_\_\_\_\_ 2011.

SIGNATURE: \_\_\_\_\_

**Please attach a cancelled cheque**

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Please Fax Back to 011 782 0270**