Membership Application Form

Please complete and send to sharon@medicaladvisors.co.za

Contact Information

Date _____

Title _____

Name | Initials _____

Surname _____

Date of Birth _____

Telephone No. _____

Cell No. _____

Fax No. _____

E-mail _____

Type of Membership Associate / Full

Support Contact Information

Please provide the contact details of your PA/Secretary/Admin Assistant should he/she handle MAG correspondence and bookings on your behalf.

Name & Surname _____

Telephone No. _____

Fax No. _____

E-mail _____

Employment Information

Employer _____

Occupation

Funds/Groups Managed

Professional Membership Information

Member of HPCSA / Other (name please) / None

HPCSA or other Membership No.

Billing Information

Please provide full details of information that should appear on your invoice.

Bill To (Company Name or Name & Surname)

Address

Postal Code

VAT No.

Responsible for payment My employer / Myself

Accounts Department Contact Name

Accounts Department Contact Telephone

Accounts Department Contact E-mail

Confirmation

I herewith verify that the above information is correct.

Signature(s) Date

Membership Fee: R300

Please pay on receipt of invoice.

Bank details will be available on your invoice.