South African Internationally Trained Health Professionals Association

[Membership Registration Form]

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(For office purposes only)

First Name/s		
Surname		
Identity Number		
Sex		
Contact Details	**Cell:**	**Landline:**
	E-mail Address:	
Physical Address [SA]		
		Code:
Postal Address [SA]		
		Code:
Foreign University of Study		
Qualification obtained		
Year in which qualification obtained		

I, …… declare that the above details are to the best of my knowledge correct and membership to the above organisation is of my free will.

The Membership subscription fee is R1200 per year.

Signature: _____ **Date:** _____

MAIL THIS FORM TO: info@saithpa.org.za

For Office Use	
Date received:	
Date application processed:	