Membership Application 2018

This agreement serves to clarify the nature and extent of co-operation between ProfNet Medical (Pty) Ltd and

Name _____

Practice name_____

Discipline _____ (One form per discipline)

This member application form serves as a membership agreement only.

I, the undersigned Healthcare Professional, undertake to complete the required questionnaires, and to assist ProfNet Medical with healthcare support information and data monitoring procedures as established by ProfNet Medical.

I hereby give ProfNet authority to identify and gather all necessary information that has been generated by my practice from the following organisations to be made available to ProfNet in order to assist on a National Healthcare Data Portal - MediKredit (Pty) Ltd, Medscheme Holdings (Pty) Ltd, HealthBridge, MediSwitch, Mediscor, Private Hospital Networks or any other Healthcare Organisations in possession of my practice data. ProfNet undertakes not to disclose any part of my practice information to any individual / health care group / third party, without my written consent.

I hereby give ProfNet consent to advise, assist, support and communicate on any current or future third party arrangements that I may independently enter into, and where appropriate, to offer administrative support and to liaise on compliance policies on my behalf.

Where appropriate, and in agreement between ProfNet and myself, I hereby give consent to commercialize my product utilization data with the Healthcare Industry.

I confirm that in the past 5 years, no claims, HPCSA (or equivalent Regulatory or Statutory body) complaints or allegations of negligence, error or omission have been made against me, nor am I aware of any circumstances which may result in any such claim, allegation or complaint being made against me. No insurer has ever cancelled, declined or refused to renew my malpractice/professional indemnity insurance. The MPS has never declined to renew my membership with them.

Sign:_____

This document also authorizes ProfNet to communicate with me via electronic media (sms and e-mail) where appropriate. One calendar months' notice period on subscription changes and contract termination is required.

Signed at _____ on _____2018

_____	_____	_____
Member: Signature	Member: Tel. number	Email address

PRACTICE & PERSONAL INFORMATION

Practice name As you would like it to appear on official documents	
Practice number (BHF no.)	
Email address This will be your username when logging in, as well as where you will receive your confirmation email.	
Title	
Initials	
Name	
Surname	
Identity no / SA ID / Passport	
Gender	
Discipline	
Regulatory council number HPCSA, AHPCSA, SANC, SACSSP, SADTC etc.	
Physical address	Building / Unit:
	Complex / Estate:
	Street address:
	Suburb:
	City/Town: | Postal Code:
Postal address	
VAT number (if applicable)	

PRACTICE ADMINISTRATION

Receptionist name			
Administrator			
Admin Tel no			
Admin Fax no			
Admin email address			
Which practice billing software do you use?			
Do you submit your claims by EDI or paper?			
Which electronic switching software do you use?			
Does your practice have a credit card machine (POS)	If Yes:	Bank:	Merchant no:
	If No:	I would like a POS Facility:	☐ Yes ☐ No
		Preferred bank:	ABSA / Nedbank / Std Bank / FNB

Healthcare Helpline

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