

## MEDICAL MALPRACTICE ASSOCIATION MEMBERSHIP APPLICATION FORM



Email Form to : [medicalmalpractice@nameandshame.biz](mailto:medicalmalpractice@nameandshame.biz)

<b>DETAILS OF APPLICANT</b>	
Membership Number ( For Office Use ) :	
Full Name :	
Employer :	
Date of Birth :	Male / Female
I.D.Number :	
<b>CONTACT DETAILS OF APPLICANT:</b>	
Postal Address:	Physical Address
Tel numbers ( W )	Fax numbers:
Tel numbers ( H ) :	Mobile number:
Mobile numbers:	
<b>DETAILS OF DOCTOR / s : ( Attach Affidavit or Letter of Complaint sent to HPCSA to this Application form )</b>	
Name	
Practice Number :	
Date of Complaint :	Location / Hospital :
Date Reported to HPCSA :	HPCSA Number :
<b>CONTACT DETAILS OF DOCTOR:</b>	
Postal Address:	Physical Address:
Tel numbers ( Surgery ) :	Fax numbers:
Tel numbers ( H ) :	Mobile number:
E-Mail address:	
<b>NATURE OF COMPLAINT Please Explain ( 50 words )</b>	