DENIS Network Application Form

Please complete this form in full and forward to DENIS

Fax: 0866 770 336
Email: thenetwork@denis.co.za

DENIS will maintain the confidentiality of the information you provide on this form unless the disclosure thereof is required by law. If your application is successful, the information supplied on this application form will become part of your DENIS Network records. Once your application is processed, you will be informed of the outcome of the application.

Practitioners' Details

Full Name:

Practice Number:

HPCSA Number:

Professional Indemnity Number (*where applicable):*

Practice VAT Registration Number:

Are you a member of any of the following professional associations:

DPA Yes No SADA Yes No DENTASA Yes No OHASA Yes No

Names and HPCSA numbers of all dentists, locums, dental therapists and oral hygienists in the practice, who claim under this practice number:

1.

2.

3.

4.

5.

6.

Are all practitioners in your practice(s) compliant with the HPCSA's CPD requirements? Yes No

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Block D, The Forum, North Bank Lane, Century City, 7441 | PO Box X1, Century City, 7446
Reg no: 1996/000371/07
www.denis.co.za

Practice Details

Physical Address *[where practice is situated]:*

Postal Code:

Postal Address:

Postal Code:

Practice Telephone Number:

Fax Number:

Cell Phone Number:

Practice Email Address:

Practice Management Details

Physical Address *[if the same as above, please indicate that]:*

Postal Code:

Postal Address of Practice Management:

Postal Code:

Practice Management Telephone Number:

Fax Number:

Cell Phone Number:

Practice Management Email Address:

Do you have satellite/additional practices? Yes | No

If yes, please list the satellite/additional practice details where applicable

1. Satellite Practice Address *[where practice is situated]:*

Postal Code:

Satellite Practice Telephone Number:	Fax Number:

2. Satellite Practice Address *[where practice is situated]:*

Postal Code:

Satellite Practice Telephone Number:	Fax Number:

Do you send laboratory work outside of your practice? Yes | No

If yes, please supply the laboratory details

Laboratory Number:

Laboratory Address:

Postal Code:

Registration Number: | Practice Number:

Identification Number:

VAT Registration Number:

Telephone Number:

Please indicate your preferred method of claim submission: Online | EDI | Paper

Please indicate your preferred method of communication: Email | Post | Phone | SMS

Please specify the IT Practice Management System currently used in your practice:

Does your practice have a card reader facility? Yes | No

Is your practice associated with any other dental network or organisation? Yes | No

If yes, name of relevant network of organisation:

Practice Facilities

IV Sedation	Yes	No
X-ray Unit	Yes	No

If yes, X-ray license number: _____

Do you accept after hours emergencies?	Yes	No
Method of instrument sterilisation	Autoclave	Other

Practice Capacity

Kindly indicate the average number of patients seen per day according to the following classifications:

Private | Medical Aid

Kindly indicate the distance of your practice from a public transport depot: km

I.....hereby declare that all information submitted is true and correct. I understand that the information that I have provided is subject to verification. I acknowledge and agree that the acceptance of my application is at the sole discretion of DENIS.

Signed **Date**