# 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. |
| 7. |
| 8. |

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

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## 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:

**Do you have satellite/additional practices?** Yes | No

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

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

Postal Code:

| Satellite Practice Telephone Number: | Fax Number: |
|---|---|

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

Postal Code:

| Satellite Practice Telephone Number: | Fax Number: |
|---|---|

**C. Satellite Practice 3:** Physical Address *[where practice is situated]:*

Postal Code:

| Satellite Practice Telephone Number: | Fax Number: |
|---|---|

**D. Satellite Practice 4:** Physical Address *[where practice is situated]:*

Postal Code:

| Satellite Practice Telephone Number: | Fax Number: |
|---|---|

**E. Satellite Practice 5:** Address *[where practice is situated]:*

Postal Code:

| Satellite Practice Telephone Number: | Fax Number: |
|---|---|

## 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:

**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

**X-ray Unit**

It is a pre-requisite to have the following at the dental practice when applying to join the DENIS Dental Network: **A licensed x-ray machine or proof of purchase of an x-ray unit**.

Is the X-ray unit registered in the applicant's name? | Yes | No |

*If yes, kindly attach the Department of Health (DoH) approved x-ray license certificate or proof of purchase.*

*If no, please provide the following information:*

**Practice number of the owner of the machine at the dental practice**

| | |
|---|---|
| Practice Number | |
| HPCSA Registration Number | |
| X-ray License Number* | |

**Please attach the Department of Health (DoH) approved x-ray license certificate.*

**Practice Facilities**

| | | |
|---|---|---|
| IV Sedation | Yes | No |
| Method of instrument sterilisation | Autoclave | Other |

**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:

## Practice Capacity

Do you accept after hours emergencies? Yes | No

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**