PCNS
PRACTICE CODE NUMBERING SYSTEM

BOARD OF HEALTHCARE FUNDERS NPC
Company Registration No. 2001/003387/08

PRACTICE NUMBER SUSPENSION REQUEST

Date: ____

Practice Number: ____

Practice Name: ____

We the undersigned request that PCNS suspends our Practice Code Number effective from: ______________________________

NB: Digital signatures are not acceptable and may delay the processing of your reinstatement.

The signature for 2 or more partners linked to this application is required unless the application is for a Solus INC then only 1 signature is required.

Full name and surname of partner:	Signature:	Individual Practice Number:	Date:
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