SANC-4-25

South African Nursing Council

(Established under the Nursing Act, 2005)

602 Pretorius Street, Arcadia, Pretoria 0083
Private Bag X132, Pretoria 0001
Telephone 012 420-1000
Fax 012 343-5400 (24-hour line)

Community Service Completion Report

Instructions:

1. *Please complete all required information using a ballpoint pen.*
2. *Print all information clearly.*
3. *All information must be supplied – this will ensure that details which may have changed during the period of Community Service are correctly updated in the register.*

Personal Details of Practitioner:

S. A. Nursing Council Reference Number																
Title (*tick ✓ one box*)	Dr		Mr		Ms		Prof									
Surname																
Given Names (in full)																
Maiden Name (if applicable)																
Sex (*tick ✓ one box*)	Female				Male											
Date of Birth *(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D						
South African Identity Number																
OR *alternatively, for those applicants who do not have a South African Identity Number:*																
– Passport Number																
– Passport Country of Issue																
– Passport Expiry Date (yyyy-mm-dd)	Y	Y	Y	Y	–	M	M	–	D	D						

NOTE:
If you have changed any of the details appearing in your identity document or passport since registering as a student and if you have not already done so, you must submit certified proof substantiating the change together with this application.

Postal Address:

Postal Code	

***NOTE**: Enter your home postal address – to be recorded in the register.*

Do not use the address of the health establishment where you performed Community Service.

Residential Address (if different):

Postal Code	

***NOTE**: Enter your home residential address here only if it is different to your postal address.*

Do not use the address of the health establishment where you performed Community Service.

Please turn over – form continues overleaf…

Address to which your registration certificate should be posted (if different):

	NOTE: *Enter the postal address to which your registration certificate and/or any correspondence in connection with your registration should be sent.* *The address details entered here will not be recorded in the register.*
Postal Code	

Contact Details:

Telephone Number (home)													
Telephone Number (work)													
Cellular phone Number													
Fax Number													
E-mail Address													

Details of Community Service:

Name of Health Establishment (where Community Service was completed)											
Name of Town / City											
Province											
Date of Commencement of Community Service	*(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D
Date of Completion of Community Service	(yyyy-mm-dd)	Y	Y	Y	Y	–	M	M	–	D	D

Signed by Practitioner:

I certify that the information provided in this report is true and correct.										
Signature:										
Date: *(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D

Please note that when this form is submitted to the Nursing Council it must be accompanied by the following:

1. Registration fees of R760-00(*) (including VAT) or proof of payment thereof into the SA Nursing Council bank account. Use SANC number followed immediately by **REGFPRA** as reference.

(*) R760 equals R380-00 for registration as Nurse plus R380-00 for registration as Midwife

The above-mentioned fee applies from **01 January 2019**. For payments received by the Council before this date, the fee is R720-00 (R360-00 + R360-00).

FOR OFFICE USE ONLY			
Check		Card	
		Cash	
		Cheque	
		Direct deposit	

Signed by Head of Public Health Establishment:

I certify that the above named practitioner has completed the required 12-month period of Community Service at this Public Health Establishment starting on the commencement date and ending on the completion date indicated above										
Signature:										
Print Name:										
Date: *(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D

Stamp of Public Health Establishment

Signed by Provincial Coordinator for Community Service:

I certify that the above named practitioner has completed the 12-month period of Community Service required in terms of the regulations, and is now eligible to be registered as Professional Nurse.										
Signature:										
Print Name:										
Date: *(yyyy-mm-dd)*	Y	Y	Y	Y	–	M	M	–	D	D