

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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