

## PRACTICE NUMBER SUSPENSION REQUEST

Date: \_\_\_\_\_

Practice Number: \_\_\_\_\_

Council Number: \_\_\_\_\_

ID Number: \_\_\_\_\_

I, (full name and surname) \_\_\_\_\_

would like to request that PCNS suspend my/our Practice Code Number effective from (date) \_\_\_\_\_

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

\_\_\_\_\_  
**SIGNATURE OF APPLICANT/NOMINATED PROXY**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**FULL NAME AND SURNAME OF APPLICANT/NOMINATED PROXY**



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