PCNS
PRACTICE CODE NUMBERING SYSTEM

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

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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