

Please, emailed this form to:
registrations@saadaonline.org.za



SOUTH AFRICA ACADEMIC DOCTORS ASSOCIATION

Application for Membership Form

Date: (Year)____/(Mon)____/(day)____

PERSONAL DETAILS			
First names			
Surname			
Id. No.:			
Gender	Male	<input type="checkbox"/>	Female
Nationality			

CONTACT DETAILS	
Cell Number	
Email address	
Physical Address	
District Municipality	
Province	

EDUCATIONAL INFORMATION

EDUCATIONAL INFORMATION	
NB: To be completed by those with doctoral qualifications	
Doctoral Qualification	
University	
Year Acquired	
Specialisation	
Topic of the study	
Please, attach copies of the PhD qualifications	

CURRENT STUDY	
NB: To be completed by doctoral candidates	
Qualification	
University	
Year	
Specialisation	
Topic of the study	
Please, attach proof of registration	

EMPLOYMENT DETAILS	
Occupation	
Organisation	
Telephone/Cell no.	
Industry	

SKILLS	
1.	
2.	
3.	
4.	

I, _____, hereby consent to the following:
a) The information provided in this application and pictures that I am part of may be utilised and/or processed to attain the SAADA's objectives. E.g., used in the online publications. Guided by Section 11 of POPI ACT NO 4 OF 2013 .
b) To abide by the SAADA Code of Conduct, policies, and procedures.
c) To pay membership fees to South Africa Academic Doctors Association; Bank: Standard, Acc. No.: 043288960
d) To uphold the aim and objectives of the organisation.

Signed _____

Date: _____

Prospective SAADA Member

For Office use				Membership number:	
Approved	<input type="checkbox"/>	Not Approved	<input type="checkbox"/>		
Date:				Officer's Signature	
Comments:					