

APPLICATION FORM for HEALTH EVALUATION

NB: Please PRINT in BLACK INK – then fax to (021) 794-0635

Full Name:

Telephone number: Cell:

Email address: Fax No:

Residential Address:

.....Postal Code.....

Postal Address:

Postal Code..... Today's Date:.....

Privacy policy: *We will not sell, trade or give your details to anyone – they are safe with us!*

Please read the statement below, and sign:

I understand that all information provided is for information only, and cannot replace the advice of a medical doctor. Sally-Ann Creed assumes no responsibility for action taken by me in using any information at any time and as such cannot be held responsible for decisions or actions taken as a result of suggestions or recommendations made to me. I also understand that there is no refund once payment has been made and information has been sent to me.

Signed:

BANKING DETAILS:

Name:	SALLY-ANN CREED CLINICAL NUTRITIONIST CC		
Bank:	Standard Bank, Constantia	Branch Code:	025309
Account Number:	275 670 872	Account Type:	Marketlink

CREDIT CARD DETAILS:

Your Name as it appears on your Card:

Number on Credit Card:

Last 3 digits on back of card: Expiry Date:

Type of card: (ie. Master, Visa)

I agree to have Sally-Ann Creed debit my credit card to the value of

Cardholder's Signature:

Your proof of payment must accompany this application if your card details are omitted. For people outside of South Africa – sorry, we take credit cards only.