## CHEMOTHERAPY FACILITY DETAILS

[To be completed by all and faxed to 0866075166 or email to info@saoc.org.za. Please also include this with the documentation]

<table>
<tr><td colspan="2">CHEMOTHERAPY FACILITY<br>[Name to appear on the Certificate]</td><td colspan="3"></td></tr>
<tr><td colspan="2">PRACTICE NUMBER - BHF<br>[BHF No used by unit for billing]</td><td colspan="3"></td></tr>
<tr><th colspan="2">Doctors Involved - Name</th><th colspan="2">HPCSA No</th><th>Personal BHF No</th></tr>
<tr><td>1</td><td></td><td colspan="2"></td><td></td></tr>
<tr><td>2</td><td></td><td colspan="2"></td><td></td></tr>
<tr><td>3</td><td></td><td colspan="2"></td><td></td></tr>
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<tr><td>9</td><td></td><td colspan="2"></td><td></td></tr>
<tr><td>10</td><td></td><td colspan="2"></td><td></td></tr>
<tr><td colspan="2">Contact Details</td><td colspan="3"></td></tr>
<tr><td colspan="2">Physical Address 1</td><td colspan="3"></td></tr>
<tr><td colspan="2">Physical Address 2</td><td colspan="3"></td></tr>
<tr><td colspan="2">Physical Address 3</td><td colspan="3"></td></tr>
<tr><td colspan="2">Physical Address 4</td><td colspan="3"></td></tr>
<tr><td colspan="2">Postal Address 1</td><td colspan="3"></td></tr>
<tr><td colspan="2">Postal Address 2</td><td colspan="3"></td></tr>
<tr><td colspan="2">Postal Address 3</td><td colspan="3"></td></tr>
<tr><td colspan="2">Telphone Numbers</td><td>Code</td><td colspan="2">Number</td></tr>
</table>

| | | |
|---|---|---|
| Office | | |
| Fax | | |
| **Practice Manager** | | |
| Name | | |
| Cell Phone | | |
| E-mail | | |
| **Notes** | | |