**PERSONAL INFORMATION FORM**

**Please complete all items either by inserting the correct information or ticking/ circling the**

**relevant item. Please complete this form in BOLD letters.**

PERSONAL DETAILS

|  |  |  |  |
| --- | --- | --- | --- |
| Start Date (DD,MM,YYYY) |  | Employee Number |  |
| Surname |  | First Names |  |
| Date of Birth |  |
| Title | Prof Dr Adv Mr Mrs Ms | Other |  |
| Preferred Name/ Nick Name |  | Initials |  |
| Ethnic Group | African | Indian | Gender | Male | Female |
| White | Coloured |
| Marital Status | S | M | D | W | Previous Surname |  |
| Preferred Language |  | Home Language |  |

CITIZENSHIP

|  |  |  |  |
| --- | --- | --- | --- |
| Passport NumberDate Issued (DD/MM/YY) Date Expiring (DD/MM/YY) |  | SACitizenship | By birth |
| / / | Permanent Residence /Naturalization |
| / / |  | Other |
| Country of Issue |  | Nationality |  |
| SA. ID Number |  |

WORK PERMIT DETAILS

|  |
| --- |
| **Should you hold a work permit, please complete the fields below.** |
| Permit Number |  | Date Issued (DD/MM/YYYY) | / / |
| Date Expiring (DD/MM/YYYY) |  |

ADDRESS DETAILS

|  |  |  |  |
| --- | --- | --- | --- |
| Permanent Address |  | Residential Address | Same as permanent address |
| Yes | No |
| Street Address Line 1 |  | **If No:** Address Line 1 |  |
| Street Address Line 2 |  | Address Line 2 |  |
| Suburb |  | Suburb |  |
| City |  | P.O. Box |  |
| Province |  | City |  |
| Postcode |  | Postcode |  |
| Telephone (H) |  | Cell Number |  |
| Telephone (W) |  | Email |  |

SARS INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Income Tax Number |  | Revenue Office |  |

SUPPLEMENTARY INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Spouses Full Name |  | Spouse Birth Date (DD/MM/YYYY) | / / |
| Spouses SA. ID Number |  |  |  |
| Do you have a Disability? | Yes | No | Disability Number |  |
| If yes, state disability condition (EE Act Requirement) |  |

NEXT-OF-KIN DETAILS/ EMERGENCY CONTACT 1

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship |  |
| Primary Contact **(Note: Please mark only one contact as primary)** | Yes | No | Address & Phone same as employee? | Yes | No |
| Residential Address: | Postal Address: |
| Street |  | Street |  |
| Suburb |  | Suburb |  |
|  |  | P.O. Box |  |
| City |  | City |  |
| Postcode |  | Postcode |  |
| Telephone (H) |  | Telephone (W) |  |
| Cell Number |  | Email |  |

DEPENDANTS

|  |
| --- |
| **Dependant 1** |
| Full Name |  | Birth Date | / / |
| SA I.D Number |  | Relationship |  |
| Gender | Male | Female | Medically Dependant | Yes | No |
| **Dependant 2** |
| Full Name |  | Birth Date | / / |
| SA I.D Number |  | Relationship |  |
| Gender | Male | Female | Medically Dependant | Yes | No |
| **Dependant 3** |
| Full Name |  | Birth Date | / / |
| SA I.D Number |  | Relationship |  |
| Gender | Male | Female | Medically Dependant | Yes | No |
|  |

|  |
| --- |
| **Dependant 4** |
| Full Name |  | Birth Date | / / |
| SA I.D Number |  | Relationship |  |
| Gender | Male | Female | Medically Dependant | Yes | No |
| **Dependant 5** |
| Full Name |  | Birth Date | / / |
| SA I.D Number |  | Relationship |  |
| Gender | Male | Female | Medically Dependant | Yes | No |

**QUALIFICATIONS: (Please start with the highest qualification)**

|  |
| --- |
| **Tertiary Education 1** |
| Institution |  |
| Qualification Obtained |  |
| Highest Qualification | Yes | No | Date Obtained (DD/MM/YYY) | / / |
| Majors/ Specialisation |  | Graduated | Yes | No |
| **Tertiary Education 2** |
| Institution |  |
| Qualification Obtained |  |
| Highest Degree | Yes | No | Date Obtained (DD/MM/YYY) | / / |
| Majors/ Specialisation |  | Graduated | Yes | No |
| **Tertiary Education 3** |
| Institution |  |
| Qualification Obtained |  |
| Highest Degree | Yes | No | Date Obtained (DD/MM/YYY) | / / |
| Majors/ Specialisation |  | Graduated | Yes | No |

 MEMBERSHIP OF PROFESSIONAL BODIES

|  |
| --- |
| **Membership of Professional Bodies 1** |
| Society Name |  | Post Held (if any) |  |
| Type of membership |  | Date Joined (DD/MM/YYYY)( | / / |
| **Membership of Professional Bodies 2** |
| Society Name |  | Post Held (if any) |  |
| Type of membership |  | Date Joined (DD/MM/YYYY) | / / |

**By affixing my signature below, I confirm that the information provided is true to the best of my knowledge.**

Signature Date