**[practice letterhead]**

**CONFIRMATION OF REQUIREMENT TO WORK DURING LOCKDOWN**

Our practice has, pursuant to regulation 11B of the Amendments to the Regulations issued under the Disaster Management Act, 2002, has identified the person whose name appears on the permit, as part of the “essential” operations of a health professional’s practice.

The practice [INSERT PRACTICE NAME] is a medical practice, and the bearer of this letter is part of ensuring the delivery of these services as essential to the provision of health care services.

S/he fulfils the role of essential support to the running of the practice.

We are compliant with all the other regulations required to implement the necessary steps during this state of disaster.

**Kindly allow the bearer of this permit to travel to and from the above address(es) in order to ensure the delivery of services exempted from the lockdown.**

If there are any queries or concerns, please contact the signatory of this permit who will verify the above.

Yours

*[signature]*

*[initials, surname]*

**PERMIT TO PERFORM ESSENTIAL SERVICE**

**Regulation 11B(3)**

*Please note that the person to whom the permit is issued must at all times carry* a *form of identification to be presented together with this permit. If no identification is presented, the person to whom the permit is issued will have to return to his or her place of residence during the lockdown*

*I,*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surname** |  | | | |
| **Full names** |  | | | |
| **Identity Number** |  | | | |
| **HPCSA Professional Nr** |  | | | |
| **Contact Details** | **Cell nr.** | **Tel Nr (W)** | **Tel Nr(H)** | **Email address** |
|  |  |  |  |
| **Physical Address of Institution** |  | | | |
| *Herby certify that:* | | | | |
| **Surname** |  | | | |
| **Full names** |  | | | |
| **Identity Number** |  | | | |
| **Physical Address** |  | | | |
| **General Hours &**  **Emergency Services** |  | | | |

is part of ensuring the delivery of the services as mentioned herein as essential to the provision of health care services of this practice.

Signed at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, on this the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2020

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Head of Institution

*Official stamp of Institution*