



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	<input type="checkbox"/> Prof <input type="checkbox"/> Dr <input type="checkbox"/> Adv <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other		
Preferred Name/ Nick Name		Initials	
Ethnic Group	African	Indian	Gender
	White	Coloured	
Marital Status	S	M	D
		W	Previous Surname
Preferred Language		Home Language	

CITIZENSHIP

Passport Number		SA Citizenship	By birth
Date Issued (DD/MM/YY)	/ /		Permanent Residence /Naturalization
Date Expiring (DD/MM/YY)	/ /		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
Street Address Line 1		If No: Address Line 1	Yes No
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	
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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/YYYY)	/ /	
Majors/ Specialisation			Graduated	Yes	No
Tertiary Education 2					
Institution					
Qualification Obtained					
Highest Degree	Yes	No	Date Obtained (DD/MM/YYYY)	/ /	
Majors/ Specialisation			Graduated	Yes	No
Tertiary Education 3					
Institution					
Qualification Obtained					
Highest Degree	Yes	No	Date Obtained (DD/MM/YYYY)	/ /	
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 _____