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**COMMUNITY SERVICES DEPARTMENT
MUNICIPAL HEALTH SERVICES**

APPLICATION FORM FOR HEALTH CERTIFICATE -ACCOMMODATION ESTABLISHMENTS

NEW APPLICATION		RE -ISSUE OF CERTIFICATE:		CERTIFICATE NUMBER:	
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A. DETAILS OF PERSON (whose name the certificate must issued).

1. Surname and full names
2. ID Number/ work Permit/Passport No.....
3. Name of establishment:.....
4. Name of the village:.....
5. Address physical.....
6. Address postal.....

B. PARTICULARS OF ACCOMMODATION ESTABLISHMENT

1. Name of Accommodation Facility.....
2. Physical Address of facility:.....
3. Erf/stand no., Farm name.....
4. Name of Manager/contact person:.....
5. Contact No.....cell.....

SERVICE PROVIDED	YES	NO
Self-catering		
Providing meals		

C. NUMBER OF ROOMS/EN-SUITE

DOUBLE ROOM	SINGLE ROOM
BATH ROOMS	BATH ROOMS

D. STAFF

Number of persons employed or to be employed:

Males	females

E. PARTICULARS OF APPLICANT

1. Surname and full names.....
2. Capacity (e.g. Owner, Managing Director, secretary, Manager).....
3. ADDRESS postal
4. Contact numbers.....cell.....

SIGNATURE:.....

DATE OF APPLICATION:.....

BANKING DETAILS:

Account holder: SEKHUKHUNE DISTRICT MUNICIPALITY.

Bank: STANDARD BANK

Account no: 271149418

Amount payable: **R450.00**

Reference: MHS -Company Name

PLEASE ATTACH

Proof of payment

Identity document (ID)