SIZWE
MEDICAL FUND
Your health in caring hands

VENDOR REGISTRATION FORM

Company Name: _____

Registration no: _____

Contact Person: _____

Physical Address: _____

_____

Phone number: _____

Email: _____

Service/products offered: _____

_____

Sizwe Medical Fund reserves the right to maintain an updated supplier list depending on the legitimacy of the documents and information supplied by the vendor.

Signature of Vendor _____ Date _____