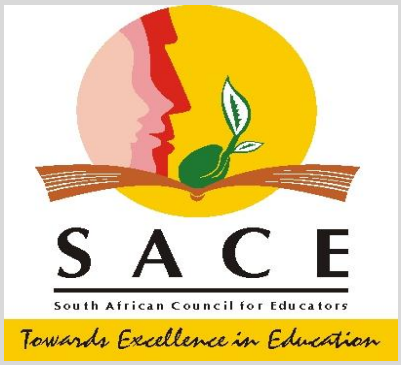
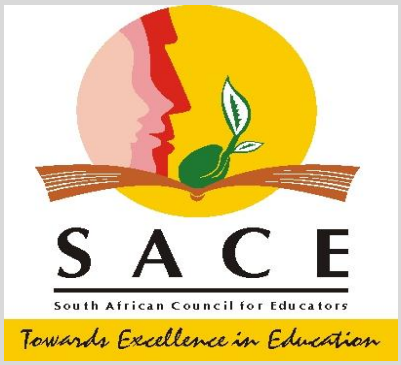
PROVIDER APPLICATION FORM



SECTION A: Provider Profile

Provider Name:				
Physical Address:				
	Province:		Code:	
Postal Address:				
			Postal Code:	
Contact Details:				
Telephone Number:				
Fax Number:				
Email Address:				
Website (if any):				
Contact Person Details:				
Name and Surname:				
Cell Number:				
Office Telephone Number				
Email address:				

PROVIDER APPLICATION FORM



Section B: **Provider Approval Information**

1. As a provider, are you Accredited with any Quality Council? (Select Yes or No)	Yes	No
2. If you are accredited with a Quality Council, please select one of the following by encircling the applicable one below:		
	UMALUSI	
	CHE's HEQC	
	ETDP SETA	
If you are Accredited with one of the Quality Councils above, please attach a certified copy of your accreditation certificate*		
3. Type of company (Select correct one)	*Higher Education Institutions*	
	Professional Association	
	NGO	
	Private	
4. If you are not accredited with a Quality Council, please submit the following information: *Tick off the box next to the required submissions to indicate that they are attached.*		
Information to be submitted:		☑
a) Purpose statement (Mission and Vision)		
b) Financial viability (Attach recent audited/financial statement or income and expenditure statement		
c) Tax Clearance (Attach a recent copy of your tax clearance certificate)		
d) Physical resources (Attach latest Municipal account or a lease agreement)		
e) Track record/references (Attach records or copies of testimonies or references from previous clients)		
5. Are you providing in collaboration with other partners? (Select Yes or No)	Yes	No
6. If you are providing in collaboration with other partners, please name them below:		
7. Are these partners accredited with any of the above quality councils? (Select Yes or No)	Yes	No
If these partners are accredited with any of the above quality councils, please attach a certified copy of their accreditation certificate*		

PROVIDER APPLICATION FORM

8. As part of our Monitoring and Evaluation Process, Site Visits will be conducted. Please attach the full details of your delivery sites containing the following information:		
i. Province:		
ii. Exact Area where delivery takes place:		
iii. Physical Address:		
	Code:	
iv. Contact Details:		
Tel:		
Cell:		
v. Facilities for Delivery		
a. Type of rooms		
b. Assignable square metres		
c. Capacity (how many people can be accommodated?)		
d. Present usage (weekly in hours)		
e. Anticipated usage (weekly in hours)		
f. Who owns the facility?		

Section C: **Provider Declaration and Code of Good Practice**

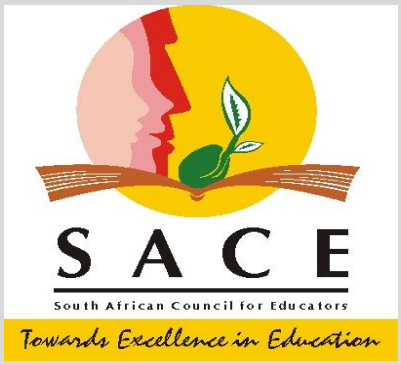
- It is our policy to ensure that we maintain and achieve the highest possible standards with respect to professional development of educators in our organization.
- We strive to give our educators the best and most effective professional development activities that meet their developmental needs and requirements.
- We will maintain and continually improve our quality management system.
- We commit to maintain and adhere to SACE approval standards and we will respect the copyright laws and avoid plagiarism by declaring all the sources used in our material
- We commit ourselves and our organizations/institutions to SACE monitored site visits
- We agree to the publication of our activities/programmes and delivery sites in the SACE professional development catalogue.
- We commit ourselves to submit reports (activities and CPTD points) on teachers who have participated in our trainings/programmes

Signed on this day ……..Of …… 20……..

Signature ……

NB: A provider who attempts to exert improper influence over any evaluator or try to offer any inducement to an evaluator in order gain their favor will be disqualified by SACE.

PROVIDER APPLICATION FORM



RETURN DETAILS TO

Attention: Mr Theo Toolo
Email:provider@sace.org.za
Fax: 086 538 5952

Postal address	**Physical address**
Private Bag x 127 Centurion 0046	Block 1 Crossway Park 240 Lenchen Avenue Centurion 0057

FOR OFFICE USE ONLY:		
Provider Number:		
Everything Submitted	Yes	No
Missing Information and Details (*if any*)		
Follow-up made with Provider (*where necessary*)		
Was Follow-Up Made? (*Indicate Yes or No*)	Yes	No
Date of Follow-up:	Day:___ Month:_____ Year:_____	

Signed By:

Name & Surname: _____

Title: _____

Signature: _____

Date: Day:____ Month: _____ Year:

Approved/checked by:

Name & Surname: _____

Title: _____

Signature: _____

Date: Day:____ Month: _____ Year: