



PROVINCE OF KWAZULU - NATAL - ISIFUNDAZWE SAKWAZULU - NATALI

DEPARTMENT OF TRANSPORT

UMNYANGO WEZOKUTHUTHA

To: Department of Transport,
Head Office
172 Burger Street
Pietermaritzburg
3201

Attention: Ms Hlengiwe Ndlovu,
Supply Chain Management (SCM)
B Block

ENTITY MAINTENANCE FORM

I _____ (full name of Departmental official) acknowledge receipt on _____ (date) of the following original Entity Maintenance form from _____ (Name of Supplier), which is attached.

I confirm that the following supporting documentation/information is attached.

- Certified copy of the ID document from the member of the public submitting the Entity Form
- Certified copy of ID document of the Owner or Director of the Entity.
- Certified copy of Telkom/Eskom/Municipal account/letter from Councillor confirming complete physical address.
- ZNT Number which has been checked against Treasury Database. Reason must be indicated if this is not available.
- Documentary proof of business with the Department. ie award letter or copy of order.
- A Valid original Tax Clearance certificate.

The Entity Maintenance form has been completed correctly in all respects and together with all the supporting documentation/information, is therefore submitted to SCM for capture on the BAS system.

Should you have any queries regarding this Entity Form or the supporting documentation, please contact _____ (Departmental officials Name) on _____ (contact number).

Submitting Officials Details:-

| | |
|-----------|--|
| Name | |
| PERSAL | |
| Telephone | |
| Office | |

SIGNATURE



**DEPARTMENT OF TRANSPORT
PROVINCE OF KWAZULU-NATAL**

SUPPLIER MAINTENANCE:

BAS

CONTRACTOR
CONSULTANT

Head Office Only

Captured By: _____
 Date Captured: _____
 Authorised By: _____
 Date Authorised: _____
 Supplier code: _____

Enquiries : _____
 Tel. No.: _____

KWAZULU-NATAL DEPARTMENT OF TRANSPORT

I/We hereby request and authorise you to pay any amounts, which may accrue to me/us to the credit of my/our account with the mentioned bank.

I/we understand that the credit transfers hereby authorised will be processed by computer through a system known as "ACB - Electronic Fund Transfer Service", and I/we understand that no additional advice of payment will be provided by my/our bank, but that the details of each payment will be printed on my/our bank statement or any accompanying voucher. (This does not apply where it is not customary for banks to furnish bank statements).

I/we understand that the Department will supply a payment advice in the normal way, and that it will indicate the date on which the funds will be made available on my/our account.

This authority may be cancelled by me/us by giving thirty days notice by prepaid registered post.

Please ensure information is validated as per required bank screens.

I/We understand that bank details provided should be exactly as per the records held by the bank.

I/We understand that the Department will not assume responsibility for any delayed payments, as a result of incorrect information supplied.

I/We will be held liable for the repayment of any funds incorrectly paid over to me/us and failure to do so may result in the Department instituting civil proceedings to recover the money so paid and that I/we will be held liable for the recovery.

Company / Personal Details

Registered Name

Trading Name

Tax Number

VAT Number

Title:

Initials:

First Name:

Surname:

Address Detail of Supplier

Payment Address

(Compulsory if Supplier)

Postal Code

New Detail

New Supplier information Update Supplier information

Supplier Type:

Individual
 Company
 CC
 Sole Prop.

Department
 Trust
 Other (Specify)

Partnership

Department Number

KZN Supplier database Number

Suppliers Details

| | |
|---|----------------------|
| ID Number | <input type="text"/> |
| Passport Number | <input type="text"/> |
| Company Registration Number | <input type="text"/> |
| *CC Registration | <input type="text"/> |
| <i>*Please include CC/CK where applicable</i> | |
| Practice Number | <input type="text"/> |

Bank Account Details

(Please note that this account MUST be in the name of the supplier. No 3rd party payments allowed).

| | |
|----------------|---|
| Account Name | <input type="text"/> |
| Account Number | <input type="text"/> |
| Branch Name | <input type="text"/> |
| Branch Number | <input type="text"/> |
| Account Type | <input type="checkbox"/> Cheque Account <input type="checkbox"/> Savings Account <input type="checkbox"/> Transmission Account <input type="checkbox"/> Bond Account <input type="checkbox"/> Other (Please Specify) <input type="text"/> |

Stamp (authorized)

Bank stamp

It is hereby confirmed that this details have been verified against the following screens

ABSA-CIF screen
FNB-Hogans system on the CIS4
STD Bank-Look-up-screen
Nedbank- Banking Platform under the Client Details Tab

Contact Details of Supplier

| | | | |
|-----------------|----------------------|----------------------|----------------------|
| Business | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | Area Code | Telephone Number | Extension |
| Home | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | Area Code | Telephone Number | Extension |
| Fax | <input type="text"/> | <input type="text"/> | |
| | Area Code | Fax Number | |
| Cell | <input type="text"/> | <input type="text"/> | |
| | Cell Code | Cell Number | |
| Email Address | <input type="text"/> | | |
| Contact Person: | <input type="text"/> | | |

Suppliers Signature

Print Name

Date (dd/mm/yyyy)

NB: All relevant fields must be completed