

Name of Supplier: .....  Post Box/Private Bag: ..... City: ..... Postal Code: ..... Street: ..... Suburb: ..... City: ..... Code: ..... Telephone Number: ..... Fax Number: ..... E Mail Address: .....	<b>BANK DETAILS</b> Account Name:..... Account Number..... Name of Bank..... Name of Branch..... Branch Code:.....  I..... (Name and surname) (ID) certify that the information supplied is the correct primary banking account of this business  Signature:.....
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DATE STAMP BANK    	For Completion by bank Manager/Authorised Person  Name:.....  ID No:.....  Signature:.....
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<b>*** PS Even if this form has been faxed the original should still be forwarded to:</b>	
Mogalakwena Municipality: Accounts Department P O Box 34 MOKOPANE 600	Tel (015) 491 9692/3/5/7/8 Fax : (015) 491 9712 E-MAIL ADDRESS: <a href="mailto:matabaned@mogalakwena.gov.za">matabaned@mogalakwena.gov.za</a> CONTACT PERSON: D Matabane

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