

**APPLICATION FORM
AFTER CARE**

Contact Mrs Annaline Norman – annaline@jankriel.co.za

Name and surname of learner: _____

Grade: _____ Date of Birth: _____ Age: _____

Street address: _____

P.O. Box: _____

Mother's name: _____ Surname: _____

Email: _____

Telephone (home): _____ Telephone (work): _____

Cell number: _____

Father's name: _____ Surname: _____

Email: _____

Telephone (home): _____ Telephone (work): _____

Cell number: _____

Please indicate your choice – 1st monthly payment : 31st January

- | | |
|--------------------------|-------------------------------------|
| <input type="checkbox"/> | Annual payment |
| <input type="checkbox"/> | Monthly payment in cash |
| <input type="checkbox"/> | Monthly payment by debit order |
| <input type="checkbox"/> | Monthly payment by internet/at ABSA |

SIGNATURE OF PARENT/GUARDIAN

DATE