

### APPLICATION FORM FOR APPRENTICESHIP BURSARIES



Name and of the company applying for the bursary allocation: \_\_\_\_\_

Address (Postal) of the company applying for the bursary allocation \_\_\_\_\_

\_\_\_\_\_

Address (Physical) of the company applying for the bursary allocation \_\_\_\_\_

\_\_\_\_\_

Contact Persons name and telephone number: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

CEO/MD name and telephone number: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Is this employer a contributing member of the Services SETA?

yes

or

no

Skills Development Levy number of employer: L \_\_\_\_\_

**A COMPANY CONTACT PERSON**  
*(Strictly a person who was involved in completing this document)*

Title \_\_\_\_\_ Surname \_\_\_\_\_

First Name \_\_\_\_\_ Initials \_\_\_\_\_

Designation \_\_\_\_\_

Telephone Number (work) \_\_\_\_\_

Cell Number \_\_\_\_\_

Fax Number (work) \_\_\_\_\_

E-mail Address \_\_\_\_\_

<u>1.4 CONFIRMATION OF BANKING DETAILS</u>	
<b>Name of bank</b>	
<b>Account number</b>	
<b>Name of account holder</b>	
<b>**Type of account</b>	
<b>Branch name</b>	
<b>Branch code</b>	

*\*\* A copy or a cancelled cheque or a bank stamp to verify bank details*

**FOR BANK USE:**

Date stamp of bank certified as correct

Payment instructions.

**To Whom It May Concern:**

*The Organisation hereby requests and authorises Services SETA to pay any amounts, which may accrue to the credit of the Organisation's account with the mentioned bank. The funds due will be transferred into the banking details provided for in Section A. Any change in banking details must be formally communicated to the Services SETA.*

Compiled by	Signature	CEO/CFO	Date
_____	_____	_____	_____

Authorised by	Signature	Financial Manager	Date
_____	_____	_____	_____

\_\_\_\_\_  
Company/Entity Registration Number

\_\_\_\_\_  
Company/Entity VAT Registration Number







<b>PART E (This part of the form must be completed by the provider who will conduct the institutional training)</b>	
1. Name of provider	
2. Accreditation/registration number of provider	
3. Has your curriculum been aligned and accredited by the relevant SETA?	
4. In the case of an application for learners with disabilities, kindly indicate if the class rooms and facilities have been adjusted to cater for the needs of persons with disabilities and if yes, please elaborate	
5. The institutional training curriculum for learners with disabilities might differ slightly from main stream curriculum, do you have resources to close gaps during the learnership period	
Date of Completion:	
<b>Completed By:</b>	
Provider Representative: ( <i>name in full</i> ):	
Signature:	

**PART F**

General Comments (if necessary) to be noted:

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Date of Completion:	
Employer Representative ( <i>name in full</i> ):	
Designation of employer representative:	
Signature:	