



## FRANCHISE APPLICATION

Confidential

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<b>Application's Name &amp; Surname</b>	<b>Date</b>
<hr/>	<hr/>
<b>ID No</b>	

**NOTE:**

The information submitted on this form will be treated by Health Island as strictly private and confidential.

Please help us by completing all sections carefully and thoroughly. Please print this form and write your response and return by fax to: (021) 439-5466 or email it to [info@healthisland.co.za](mailto:info@healthisland.co.za). This form will help you prepare and present personal information that is essential for our consideration in granting a franchise. The completion of this application form places no continuing obligation on either Health Island or you.

Health Island welcomes applications from all sectors of the community regardless of gender, marital status, disability or ethnic origin.

**PART A: - GENERAL INFORMATION**

Full Name: \_\_\_\_\_

Home Address:  
\_\_\_\_\_  
\_\_\_\_\_

Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Previous Address (If less than 4 years in current address): \_\_\_\_\_  
\_\_\_\_\_

Nationality: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Nature of Franchise interested in: Sole Proprietorship  Partnership  Limited Corporation  Close Corporation Business Trading Name and Registration No (if applicable):  
\_\_\_\_\_

VAT Registration No (if applicable): \_\_\_\_\_

In which area would you be most interested in running a Health Island Franchise operation?

Northern Cape  Eastern Cape  Western Cape  Free State   
North West  Gauteng  Mpumalanga  Kwazulu Natal  
 Limpopo 

Please specify area or town: \_\_\_\_\_

Please specify suburb: \_\_\_\_\_

Please specify specific site(s): \_\_\_\_\_  
\_\_\_\_\_

How much cash do you have available to invest in a Health Island Franchise?

R \_\_\_\_\_

Will you require financing for this franchise? Yes  No

Have you or your spouse ever declared personal bankruptcy? If yes, please explain:

\_\_\_\_\_

How and where did you hear about Health Island Franchising opportunities?

\_\_\_\_\_

Why do you think you are suited to becoming a successful Franchisee?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In which personal areas would you have to improve to become a successful Franchisee?

\_\_\_\_\_

\_\_\_\_\_

Will you be running this franchise alone? Yes  No

If 'No', please provide name, ID No and relationship with other party?

\_\_\_\_\_

- Will you devote your full time to the business?                      Yes                       No
- Do you have your own PC and internet access?                      Yes                       No
- Do have a current driving licence?                      Yes                       No
- Do you have your own reliable transport?                      Yes                       No

**History of Convictions:**

Have you ever been convicted of any criminal offence?    Yes                       No   
 If yes, please give details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART B – EDUCATION**

**Higher Education:** i.e. education since leaving school. Include qualifications.

Course Description	Qualifications	Year	Name & Address of Institution
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Secondary Education:** i.e. to normal school leaving age, 16 or 18.

Highest level attained at School: \_\_\_\_\_

Name of school: \_\_\_\_\_

City: \_\_\_\_\_

Year completed: \_\_\_\_\_

**PART C – BUSINESS EXPERIENCE**

Have you had any experience in the food industry?      Yes       No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had any experience in the health industry?      Yes       No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**References:** Please give details of two business or academic references. (No contact will be made until you are accepted into the Franchise programme).

Name	Address	Occupation	No. of years known
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PART D– WORKING HISTORY**

Please list your current and/or most recent jobs/occupations, most recent first:

1) Current/Most Recent:

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Employer/Name of Business: \_\_\_\_\_

Position Held: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

2) Previous Job 1:

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Employer/Name of Business: \_\_\_\_\_

Position Held: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

3) Previous Job 2:

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Employer/Name of Business: \_\_\_\_\_

Position Held: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**PART D– BANK DETAILS:**

Bank Name: \_\_\_\_\_

Branch Name: \_\_\_\_\_

Branch Code: \_\_\_\_\_

Account Holder's Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

**Please support this document with relative documentation:**

- Registration documents of intended trading company/closed corporation (if applicable)
- Certified copies identity documents of all the members, shareholders or partners concerned with the Franchise
- Receiver of Revenue – VAT (if relevant)

*I hereby declare that, to the best of my knowledge and belief, the above statement and particulars are true and complete. I also authorise you to make any enquiries you consider necessary in connection with this application. I am aware that, should this application be refused, no reason needs to be given.*

*I understand that any misrepresentation of factual information requested on this application form may be cause for removal from the Health Island system.*

Name and Surname: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_