SURGICAL CINEMA

SURGICAL CINEMA

STUDENT REGISTRATION, RELEASE & CREW FORM

Full Name:

Date of Birth / Age: **Contact Number:**

Email Address:

Social Media Handles (Instagram / TikTok / LinkedIn / etc.):

Emergency Contact (Name & Phone):

Workshop Option (Tick One):

- ☐ 1-Day Workshop (Filming & Production) ~~-~~**R4,500**
- ☐ 2-Day Workshop (Filming & Editing) ~~-~~**R6,000**

Preferred Role / Skill Focus (Tick Top Choices):

- ☐ Directing
- ☐ Cinematography
- ☐ Lighting
- ☐ Sound
- ☐ Editing
- ☐ Production Management

Equipment Check:

Phone: iPhone 13 Pro Max or newer / Flagship Android

Do you have one? ☐ Yes ☐ No (Need provided gear)

Storage: 256GB+ USB or Fast Speed SD Card

Do you have one? ☐ Yes ☐ No (Need provided gear)

Credit Name (How your name should appear on DStv credits & certificate):

FOOTAGE OWNERSHIP, RELEASE & USAGE CLAUSE

- **Workshop & Broadcast Ownership:** The workshop / production company retains full ownership of all footage captured during the workshop, including behind-the-scenes (BTS) footage featuring the student, and may freely use this footage for broadcast, streaming, promotional, and marketing purposes to recruit future students.
- **Student Co-Ownership & Non-Alteration:** The student holds co-ownership of their delivered episode/copy for personal showcase purposes only, provided that the delivery file is not altered, color-graded/changed, or re-edited in any way after handover.
- **Reposting & Tagging Requirement:** The student may repost and distribute their unaltered copy on social media and other platforms, subject to sharing their social media handles with us and always tagging/copying in the official workshop handles/tags on every post or share.

☐ I have read, understood, and agree to the Footage Ownership, Release & Usage Clause above as well as the workshop Terms & Conditions.

Student Signature: **Date:**

PARENT / LEGAL GUARDIAN CONSENT (REQUIRED IF STUDENT IS UNDER 18)

I confirm that I am the parent or legal guardian of the under-18 student named above. I give my full consent for them to attend the Surgical Cinema workshop, participate in filming activities, appear in behind-the-scenes content, and be bound by the Footage Ownership, Release & Usage Clause and Terms & Conditions above.

Parent / Guardian Full Name: _____

Relationship to Student: _____ **Contact Number:** _____

Parent / Guardian Signature: _____ **Date:** _____

Account Confirmation Letter

CAPITEC

SkyQR reference: 614e-5859-2f76

Capitec Bank

24/11/2026
Branch: 450105
Device:

SkyQR Download on the App Store GET IT ON Google Play
Validate this document by using the SkyQR App
or visit www.capitecbank.co.za/verify-authenticity

To Whom it May Concern

We hereby confirm that ELITE DOCTOR (PTY)LTD has the following account(s) at Capitec Bank Limited on 24/11/2026:

Client Details

Name:	ELITE DOCTOR (PTY)LTD
Registration/ID Number:	2026/415746/07
Address:	13 Queens Close, Parklands, Western Cape, 7441

Account Details

Account Status:	Active
SWIFT Address	CABLZAJJ
Account Type:	Capitec Business Account
Account Name:	ELITE DOCTOR (PTY)LTD
Account Number:	1056108584
Bank Name:	Capitec Business
Branch Name:	Relationship Suite
Branch Code:	450105
Date Opened:	2026-11-24

The account details provided herein should not be read as extending by implication to any other matters not specifically addressed. The account details are given as at the above date and no obligation is hereby assumed to update the account details on any future date.

Capitec Bank Limited shall have no liability whether in contract, delict (including without limitation negligence) or otherwise to the above accountholder or any third party in relation to the account details contained herein.