Application Form No.:

 (for official use)

|  |  |
| --- | --- |
| SMC LOGO | **SINGAPORE MEDICAL COUNCIL**16 College Road, #01-01 College of Medicine Building, Singapore 169854E-mail Address: SMC@spb.gov.sg Website: http://www.smc.gov.sgFax Number: (65) 6221-0558 |

**APPLICATION FORM TO PERFORM AESTHETIC PROCEDURES LISTED IN TABLE 1**

**VERIFICATION OF CERTIFICATE OF COMPETENCE (“COC”)**

Doctors who have not performed the requisite number of aesthetic procedures listed in Table 1 from 1 October 2006 to 30 September 2008 and who have not obtained a COC thus far but who have acquired a certificate (overseas or local training courses) and who intend to perform aesthetic procedures listed in Table 1 should submit this Application Form (together with copies of their certificates) to the Aesthetic Practice Oversight Committee for verification whether it could be considered a COC.

*Please fill in the required information clearly.*

**1. Personal Particulars of Doctor**

|  |  |
| --- | --- |
| Full Name: |   |
|  |  |
| MCR Number: |   |
|  |  |
| Registered Specialty: |   |
|  |  |
| Clinic’s Name: |   |
|  |  |
| Clinic’s Address: |   |
|  |  |
| Telephone Numbers: |   | (O) |   | (HP) |
|  |  |
| Email Address: |   |

**2. Information on Medical Malpractice Insurance**

*Note*: It is recommended that doctors who have been performing aesthetic procedures have sufficient and appropriate medical malpractice insurance to safeguard patients’ interests.

|  |  |
| --- | --- |
| Name of Insurance Provider: |   |
|  |  |
| Type of Insurance: |   |
|  |  |
| Start Date of Insurance: |   |
|  |  |
| Period of Insurance: |   |
|  |  |
| Premium Amount:  |   |
|  |  |

**3. Declaration to Perform Aesthetic Procedures under Table 1**

*Please attach with this application form, a copy of the certificate obtained (overseas or local training), details of training courses, organisers, trainer(s)’ name and CV, details of hands-on experience, duration of course, examinations / tests, course fees and details of sponsorship (if sponsored).*

|  |  |  |
| --- | --- | --- |
| **Type of Procedure** | **Tick**(Where Applicable) | **Title of Certificate Obtained** |
| **Non-invasive** |  |  |
| Chemical or Pressurised Gas / Liquid Peels |[ ]    |
| Intense Pulsed Light (IPL) – Skin Rejuvenation  |[ ]    |
| Radiofrequency, Infra-red, Ultrasound and other light-based devices, e.g. for Skin Tightening, Skin Rejuvenation   |[ ]    |
| Lasers / IPL for Hair Removal  |[ ]    |
| Photodynamic Therapy |[ ]    |
| Photopneumatic Therapy |[ ]    |
| External Lipolysis (Heat / Cold / Ultrasound) |[ ]    |
| **Minimally Invasive** |  |  |
| Botulinum Toxin Injection |[ ]    |
| Filler Injection (Face, Neck and Hands only) |[ ]    |
| Sclerotherapy |[ ]    |
| Thread lifts |[ ]    |
| Lasers for treating Vascular Disorders |[ ]    |
| Lasers for Pigmentary Disorders  |[ ]    |
| Fractional Lasers for Skin Rejuvenation |[ ]    |
| Ablative Lasers for Benign Tumours |[ ]    |
| **Invasive** |  |  |
| Free Fat Grafting (Body) |[ ]    |
| Hair Transplantation  |[ ]    |
| Dermabrasion (Mechanical)  |[ ]    |

**More Information on the Certificate(s)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title of Certificate Obtained** | **Year Obtained** | **Name of Organiser** | **Trainer’s Name(s)** | **Details of Hands-on Experience** | **Duration** | **Details of any Examinations / Tests** | **Course Fees** | **Details of Sponsorship** |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |

**4. Declaration**

I declare that the information provided in this application form is true and authentic and herein remains unchanged to-date. To the best of my knowledge and belief, I have not withheld any material fact. I understand that my practice may be audited. I also note that I may be required to submit additional details for further assessment / review.

 Signature and Name of Doctor Date

Please submit your application form and supporting documents to:

Chairman

Aesthetic Practice Oversight Committee

c/o Secretariat of Singapore Medical Council

16 College Road #01-01

College of Medicine Building

Singapore 169854

Alternatively, you may email to SMC@spb.gov.sg