

Allied Health Professions Council c/o Secretariat of healthcare Professional Boards (SPB) 81 Kim Keat Road #10-00 Singapore 328836

Email: AHPC@spb.gov.sg

Website: https://www.ahpc.gov.sg

AHPC-2409-LU-05

FORM SF2 UNDERTAKING BY SUPERVISOR

INSTRUCTIONS:

- 1. This form is to be completed by all supervisor(s) assigned by the employer to supervise the Conditionally or Temporarily registered allied health professionals.
- 2. This form must be submitted to the Allied Health Professions Council (AHPC) at the time of registration application of an allied health professional with less than 1 year or no professional practice experience in Singapore; or when there is a change in the supervisor assigned by the employer.
- 3. Section B of this form must be acknowledged by the Head of Department.
- 4. The completed form must be sent to the Secretariat staff in PDF format via email.

SECTION (A): TO BE COMPLETED BY THE SUPERVISOR				
Profession: Occupational Therapist Diagnostic Radiographe	_ , .	Therapist		
Name of Supervisor:				
Registration No: Designation:				
Institution and Department:				
Practice Address:				
Employment Status: W	Vorking Full time Minimum 40 hours per week)	Working Part time (Please specify hours per week):		
Email address:		Contact No:		

I will be the Prim	ary / 🗌 Second	dary supervisor for:		
Name of conditional	/ temporary AF	IP:		
Designation:				
Institution and Depa	rtment:			
Practice Address:				
Period of Supervision		t date (DD/MM/YY) — I date (DD/MM/YY)		
Supervision Level: [L1 / L2 / [L3		
Current list of supervisees under my supervision:				
i(Na	ame)	Primary Superviso		
ii.			Conditional / Temporary	
	ame)	Primary Superviso Secondary superv	1	
iii(Na	ame)	Primary Superviso Secondary superv		
		, ,	e that I am not personally related to	
the above-mentioned supervisee and that he/she is not employed in a practice which is owned				
by any person whom he/she is personally related to. The information provided above is true				
to the best of my knowledge, and I have read the Supervised Practice Guidelines ¹ and Code				
of Professional Conduct issued by the Allied Health Professions Council and undertake to				
comply with these gu	idelines.			
SIGNATI	URE OF SUPE	RVISOR	DATE	

¹ The guidelines are available on AHPC website: http://www.ahpc.gov.sg. Please print a hardcopy for your own reference.

I declare that: 1. My organisation/ department meets the readiness review requirements of at least 2 full time², fully registered supervisory grade staff³ at this point of time. 2. The information provided is true to the best of my knowledge. 3. I will inform AHPC of any change in my organisation's readiness review status immediately. NAME AND DESIGNATION SIGNATURE DATE

² Please refer to the Ministry of Manpower's prevailing guidelines.

³ With at least 3 years of clinical practice experience in Singapore in the respective profession.