



SINGAPORE DENTAL COUNCIL

81 Kim Keat Road, #09-00 NKF Centre, Singapore 328836

✉ SDC@spb.gov.sg

🌐 <https://www.healthprofessionals.gov.sg/sdc>

For official use

Notification Form No.: AFP _____(new)

RAFP _____(renewal)

APPLICATION FORM TO PERFORM AESTHETIC FACIAL PROCEDURES

Please fill in the required information clearly and use capital letters only. Please tick the boxes (where appropriate):

- APPLICATION TYPE** : New
 Renewal (1st) (provide expiry date for earlier approval _____)
 Renewal (subsequent) (provide expiry date for earlier approval _____)

1. PERSONAL PARTICULARS OF DENTIST

FULL NAME (NRIC) : _____

DCR NUMBER : _____

Are you a registered OMS? Yes / No* (if yes, please state your period of specialist registration from _____ to _____)

CLINIC'S NAME : _____

CLINIC'S ADDRESS : _____

RESIDENTIAL ADDRESS : _____

TELEPHONE NUMBERS : _____ (H) _____ (O)
 _____ (HP) _____ (Fax)

EMAIL ADDRESS : _____

2. INFORMATION ON DENTAL MALPRACTICE INSURANCE

Note: It is highly recommended that dentist who performs aesthetic facial procedures has sufficient and adequate dental malpractice insurance.

NAME OF INSURANCE PROVIDER : _____

TYPE OF INSURANCE : _____

START DATE OF INSURANCE : _____

PERIOD OF INSURANCE : _____

PREMIUM AMOUNT : _____

* Delete as appropriate
SDC / AFP Application form correct as at 1 Feb 2020

3. DECLARATION TO PERFORM AESTHETIC FACIAL PROCEDURES

(a) Dental practitioner registered under full registration with the Singapore Dental Council:

Table 1			
Type of procedure	Tick	Name of Certificate of Competency Course attended	No. of Procedures performed
Chemical or pressurised gas/liquid peels			
Botulinum toxin injection			
Dermal filler injection (restricted to perioral region)			

(b) Dental practitioner registered as specialist in oral and maxillofacial surgery with the Singapore Dental Council:

Table 2			
Type of procedure	Tick	Conditions	Certification/Proof ²
Procedures requiring certification or proof of relevant training			
Dermal filler injection		COC	
Intense pulsed light (IPL) for skin rejuvenation		AAAM ³ Level 1 certification/equivalent or Proof of relevant surgical training and experience required	
Radiofrequency, infra-red, ultrasound and other light-based devices for facial aesthetic enhancement		AAAM Level 1 certification/equivalent or Proof of relevant surgical training and experience required	
Lasers for pigmentary disorders		AAAM Level 1 certification/equivalent or Proof of relevant surgical training and experience required	
Lasers for treating vascular disorders		AAAM Level 1 certification/equivalent or Proof of relevant surgical training and experience required	
Sclerotherapy		AAAM Level 1 certification/equivalent or Proof of relevant surgical training and experience required	

² Documentary proof of training to be attached, e.g. logbook, preceptorship, workshops, courses, HMDP, etc.

³ AAAM = American Academy of Aesthetic Medicine
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Procedures requiring proof of relevant training			
Blepharoplasty (including double eyelid)		Proof of relevant surgical training and experience required	
Brow lifts		Proof of relevant surgical training and experience required	
Dermabrasion		Proof of relevant surgical training and experience required	
Fractional lasers for skin rejuvenation		Proof of relevant surgical training and experience required	
Free fat grafting (face)		Proof of relevant surgical training and experience required.	
Hair transplantation		Proof of relevant surgical training and experience required.	
Otoplasty		Proof of relevant surgical training and experience required	
Rhinoplasty		Proof of relevant surgical training and experience required.	
Rhytidectomy		Proof of relevant surgical training and experience required	
Submental liposuction		Proof of relevant surgical training and experience required	
Thread lifts		Proof of relevant surgical training and experience required	

4. DECLARATION

I declare that the information provided in this notification 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 Dentist / DCR number

Date

Please submit your notification form to:

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