SINGAPORE DENTAL COUNCIL
16 College Road, #01-01 College of Medicine Building, Singapore 169854

Fax Number: (65) 6253 3185
E-mail Address: SDC@spb.gov.sg

Notification Form No.:________________
(for official use)

NOTIFICATION FORM TO PERFORM LIST A AESTHETIC FACIAL PROCEDURE

Dentists who have started or intend to start performing aesthetic facial procedures from 3 June 2013 must acquired a certificate of competency (overseas or local training courses) and submit this List A Notification Form (together with copies of their certificates) to the SDC for verification whether it could be considered a certificate of competence (COC).

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

1. PERSONAL PARTICULARS OF DENTIST

FULL NAME (NRIC) : ____________________

DCR NUMBER : ____________________

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 recommended that dentists who have been performing aesthetic facial procedures have sufficient and appropriate dental 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 LIST A AESTHETIC TREATMENTS & PROCEDURES

Please attach with this notification 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 treatment and procedure	Minimum level of competence required *	*Tick	Description of training obtained/Title of certificate
Non-invasive			
Chemical or pressurized gas/liquid peels	BDS (COC)		
Microdermabrasion	Oral and Maxillofacial Surgeon		
Intense pulsed light (IPL)	Oral and Maxillofacial Surgeon		
Radiofrequency, Infrared and other light-based devices e.g. for skin tightening or hair removal	Oral and Maxillofacial Surgeon		
Lasers (non-ablative) for hair removal	Oral and Maxillofacial Surgeon		
Photodynamic/ photopneumatic therapy	Oral and Maxillofacial Surgeon		
External lipolysis (heat/ ultrasound)	Oral and Maxillofacial Surgeon		
Minimally invasive			
Botulinum toxin injection**	BDS (COC)		
Filler injection	BDS (COC)		
Sclerotherapy	Oral and Maxillofacial Surgeon		
Thread lifts	Oral and Maxillofacial Surgeon		
Lasers for - treating vascular lesions and skin pigmentation - skin rejuvenation (eg fractional lasers)	Oral and Maxillofacial Surgeon		

Type of treatment and procedure	Minimum level of competence required *	*Tick	Description of training obtained/Title of certificate
Invasive			
Blepharoplasty (including double eyelid)	Oral and Maxillofacial Surgeon		
Brow lift	Oral and Maxillofacial Surgeon		
Free fat grafting	Oral and Maxillofacial Surgeon		
Hair transplantation	Oral and Maxillofacial Surgeon		
Implants (excluding dental implants)	Oral and Maxillofacial Surgeon		
Lasers (ablative eg. CO_2 / YAG) for skin resurfacing	Oral and Maxillofacial Surgeon		
Liposuction + (traditional/water assisted / VASER / laser)	As per MOH special licensing conditions for liposuction		
Rhinoplasty	Oral and Maxillofacial Surgeon		
Rhytidectomy (facelift)	Oral and Maxillofacial Surgeon		
Dermabrasion (mechanical)	Oral and Maxillofacial Surgeon		
Submental Liposuction	Oral and Maxillofacial Surgeon		
Otoplasty	Oral and Maxillofacial Surgeon		

More Information on the Certificate(s)

Name of applicant	DCR No.	Procedure (B/F/CP)	Course Name	Organization	Date (from)	Date (to)	No. of hours	Venue	Written test (Y/N)	Practical test (Y/N)	Hands-on (Y/N)	Lecture (Y/N)	Live demo (Y/N)	Supervised clinical practice (Y/N)	Main instructor

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 Date

Please submit your notification form to:

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