Application Form No.:

 (for official use)



**SINGAPORE MEDICAL COUNCIL**

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

E-mail Address: SMC@spb.gov.sg

Website: http://www.smc.gov.sg

Fax Number: (65) 6221-0558

**APPLICATION FORM TO PERFORM NON-LISTED AESTHETIC PROCEDURES**

**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 or intend to do so 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. Name(s) of Non-Listed Aesthetic Procedure(s)**

Note: Each procedure should be supported with the necessary regulatory approvals for the clinical trial and/or at least three key scientific papers in the English language.)

|  |
| --- |
|   |
|   |
|   |

**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 and that I may be required to provide more information.

 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