Application Form No.:

(for official use)

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| SMC LOGO | **SINGAPORE MEDICAL COUNCIL**  16 College Road, #01-01 College of Medicine Building, Singapore 169854  E-mail Address: [SMC@spb.gov.sg](mailto:SMC@spb.gov.sg)  Website: http://www.smc.gov.sg  Fax 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** |
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**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](mailto:SMC@spb.gov.sg)