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 B OR OTHER AESTHETIC FACIAL PROCEDURES

Please use capital letters only.

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 or intend to do so 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. NOTIFICATION TO PERFORM LIST B OR OTHER AESTHETIC FACIAL PROCEDURES

(A) Please tick the appropriate box(es):

List B

- ☐ Mesotherapy
- ☐ Carboxytherapy
- ☐ Microneedling dermaroller
- ☐ Skin whitening injections
- ☐ Stem cell activator protein for skin rejuvenation
- ☐ Negative pressure procedures (e.g. Vacustyler); and
- ☐ Mechanised massage (eg. “slidestyler”, endermologie” for cellulite treatment)

(B) Other aesthetic facial procedure(s) (please specify):

____

____

____

(C) Experience with the Aesthetic Facial Procedure(s) as indicated in 3(A) and 3(B)
(please tick and fill in the required information accordingly)

☐ Yes, I have been performing the List B / Other Aesthetic Facial Procedure(s) since ________________ (dd/mm/yyyy).

☐ No, I am intending to provide the List B / Other Aesthetic Facial Procedure(s) with effect from ________________ (dd/mm/yyyy).

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 and that I may be required to provide more information.

______________________________ ________________________
Signature and Name of Dentist Date

Please submit your notification form to:

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