



SINGAPORE DENTAL COUNCIL
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 Email: SDC@sph.gov.sg

APPLICATION FOR ORAL HEALTH THERAPIST DISPLAYABLE QUALIFICATIONS

(Please complete one application form for each qualification applied for)

Name of OHT _____ DCR No _____

Qualification _____

Abbreviation _____ Year of Conferment _____

Awarding Institution _____

Please attach documentary verification of:

- certified true copy of the certificate (by issuing institution or law firm). If not available, please arrange to bring your original certificate for sight verification
- information about the awarding institution and its recognition by local authorities, course syllabus and structure and format of assessment

Signature of Applicant _____ Date _____

For official use only

Application No

O	H	T	D	Q	1	4			
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 Date of approval _____

Remarks

