# SINGAPORE MEDICAL COUNCIL

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## APPLICATION FOR TEMPORARY REGISTRATION FOR TRAINING AS A CLINICAL FELLOW

**(To be completed by the training institution in Singapore and sponsoring institution in applicant's home country)**

Important Notes
Please provide all information below. Applications with incomplete information will not be processed. Please attach a separate sheet if the space provided is insufficient.

### Section A: To be completed by the training institution in Singapore

| | |
|---|---|
| Name of Applicant | |
| Training Institution / Department(s) | |
| Title of Training Programme | |
| Date of Accreditation | |
| Expiry Date of Accreditation | |
| Duration of Training | _____ months |

**Is the applicant admitted under a memorandum of understanding (MOU)?**

| | |
|---|---|
| Government-to-Government | Yes* / No (Please delete as appropriate) |
| Overseas regional authority-to-Singapore institution | Yes* / No (Please delete as appropriate) |
| Overseas institution-to-Singapore institution | Yes* / No (Please delete as appropriate) |

* Institution's HR will be asked to send a copy of the MOU/official supporting document.

| | |
|---|---|
| Name/Designation of Institution's Training Coordinator in Singapore | |
| Tel No and Email Address | |
| Date | |

## Section B: To be completed by the applicant's Sponsoring Institution in the home country

*Note: Section C must be completed if the sponsoring institution is not a government or regional health authority*

| | |
|---|---|
| Name of Sponsoring Institution, and City, State and Country | |
| State the Area of Need in healthcare development of the home country requiring the fellowship training in Singapore | |
| Specify the objectives of the fellowship, including:<br><br>a) the level of entry<br>b) the desired level of skill or competency attained at the conclusion of the fellowship,<br>c) details of the level of knowledge, experience and skills to be acquired. | |
| Please state:<br><br>a) details of the local training programme that the training fellow had been a part of in the home country<br><br>b) details of the local training programme in the home country that the training fellow will continue to participate in after the conclusion of the fellowship | |

| | | | |
|---|---|---|---|
| Institutional Administrator's name and designation | | | |
| Email Address | | Date | |
| Official stamp of the institution or authority | | | |

## Section C: To be completed by the applicant's sponsoring institution in the home country, if the institution is not a government or regional health authority

### Profile of Sponsoring Institution

| | |
|---|---|
| No. of hospital beds | |
| List the clinical departments in the institution<br>*(a printout can be provided)* | |
| Level of healthcare provided (e.g. whether primary, secondary or tertiary) | |
| Size of community served | |
| No. of patients seen per year in the area of need to be developed | |

### Role of Fellow

| | |
|---|---|
| Please specify the role of the training fellow in the institution prior to the fellowship as well as after the conclusion of the fellowship | |

| | | | |
|---|---|---|---|
| Institutional Administrator's name and designation | | | |
| Email Address | | Date | |
| Official stamp of the institution or authority | | | |