ALLIED HEALTH PROFESSIONS COUNCIL

16 College Road, #01-01,
College of Medicine Building,
Singapore 169854
Website: www.ahpc.gov.sg
Email: ahpc@spb.gov.sg

Form RR5

AHPC-1604-ARPC-02

APPLICATION / RENEWAL FORM FOR PRACTISING CERTIFICATE

Important Note: Incomplete application or application submitted without the application and practising certificate fees will not be processed.

INSTRUCTIONS TO APPLICANT:

1. Fill in all sections of the Application Form clearly in blue/black ink and in capital letters.
2. The completed Application Form (original) with the application and practising certificate fees[1] shall be forwarded to the AHPC.

[1] The prescribed application fee of SGD20 and practising certificate fee of SGD140 for per year part thereof are non-refundable and may be paid by cheque or Cashier's Order. Payments by cheque should be crossed and made payable to the "Allied Health Professions Council".

****Important Note**: Renewal of practising certificate shall be made no later than 30 days before the expiration of your current practising certificate. A late application fee of SGD 100 shall be charged for late renewals.

Please tick the relevant box:

☐ New Practising Certificate ☐ Renewal of Practising Certificate

(I) PERSONAL PARTICULARS OF APPLICANT

1. Salutation *(eg. Professor, Dr, Mr, Mrs, Ms)*	2. Full Name as shown in NRIC / Work Pass / Passport* *(Please underline Family Name)*
3. AHPC Registration Number	4. Type of Profession ☐ Occupational Therapist ☐ Diagnostic Radiographer ☐ Physiotherapist ☐ Radiation Therapist ☐ Speech-Language Therapist
5. Residential Address in Singapore *(Please include Postal Code)*	6. Mailing Address in Singapore *(if not the same as item 5)*
7. Telephone Number in Singapore +(65) ________________________ (Home) +(65) ________________________ (Mobile)	8. Email Address

****delete whichever is not applicable***

(II) WORK EXPERIENCE OF APPLICANT

9. Current or Prospective Employment in Singapore		
9a. Name and Address of Employer *(Please include Postal Code)*		
9b. Address of Principal Place of Practice *(Please include Postal Code)*		
9c. Tel (Office)	9d. Fax (Office)	9e. Job Title / Appointment of Applicant
9f. Status of Employment ☐ Working Full-time *(Minimum 40 hours per week)*	☐ Working Part-time *(Please specify sessions/hours per week)*______________________________	

(III) DECLARATION BY APPLICANT

10. Please answer all questions.		
(i) Have you ever suffered or are you suffering from any physical or mental illness which may: (a) impair your ability to practise as an allied health practitioner; or (b) require conditions and/or restrictions being imposed on your registration?	☐ Yes	☐ No
(ii) Have you ever consulted a psychiatrist or are you currently undergoing psychiatric treatment?	☐ Yes	☐ No
(iii) Are you currently or have you ever been the subject of an inquiry or proceedings by a professional body, health authority or court of law in Singapore or elsewhere, involving or relating to any physical or mental illness suffered by you?	☐ Yes	☐ No
(iv) Are you currently or have you ever been the subject of an inquiry or an investigation by any professional body, licensing authority, health authority or the police, in Singapore or elsewhere, the subject matter of which may form the basis of professional misconduct or any improper conduct which may bring disrepute to the allied health profession?	☐ Yes	☐ No
(v) Have you, at any time before the submission of this application, ever been convicted in a court of law in Singapore or elsewhere of any offence?	☐ Yes	☐ No
(vi) If you have answered 'Yes' to any of the questions, please provide full details and attach supporting documents where applicable: ____ ____		

(vii) I declare that the particulars stated in this application and the documents attached are true and authentic, and the information contained herein remains unchanged to date. To the best of my knowledge and belief, I have not withheld any material fact.

(viii) I acknowledge that the Allied Health Professions Council shall have the right to withhold and/or terminate my registration and/or take any other action it deems fit, if any of the above information or documents tendered is found subsequently to be false. I am also aware that it is a criminal offence to make any false statements, to provide any false information and/or document(s) to the Allied Health Professions Council. I also understand and give my consent to the Allied Health Professions Council to make any enquiries or obtain any information & documents that it deems appropriate to establish my fitness to practise.

______________________________ Signature of Applicant

____________________ Date

<< END >>

FOR OFFICIAL USE:		
Date Received:	Bank:	Cheque / Cashier's Order No.:
Practising Certificate Serial Number:		Valid Till: