

I will be the Primary / Secondary supervisor for:

Name of conditional / temporary AHP: _____

Designation: _____

Institution and Department: _____

Practice Address: _____

Period of Supervision: Start date _____ (DD/MM/YY) –
End date _____ (DD/MM/YY)

Supervision Level: L1 / L2 / L3

Current list of supervisees under my supervision:

i. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3
ii. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3
iii. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3
iv. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3
v. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3
vi. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3
vii. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3
viii. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3
ix. _____ (Name)	<input type="checkbox"/> Primary Supervisor <input type="checkbox"/> Secondary supervisor	<input type="checkbox"/> Conditional / <input type="checkbox"/> Temporary <input type="checkbox"/> L1 / <input type="checkbox"/> L2 / <input type="checkbox"/> L3

I _____ (name) declare that I am **not** personally related to the above mentioned supervisee and that he/she is **not** employed in a practice which is owned by any person whom he/she is personally related to. The information provided above is true to the best of my knowledge, and I have read the Supervised Practice Guidelines¹ and Code of Professional Conduct issued by the Allied Health Professions Council and undertake to comply with these guidelines.

SIGNATURE OF SUPERVISOR	DATE

SECTION (B) : ACKNOWLEDGEMENT BY HEAD OF DEPARTMENT

I confirm that the information provided is true to the best of my knowledge.

NAME AND DESIGNATION	SIGNATURE	DATE

¹ The guidelines are available on AHPC website: <http://www.ahpc.gov.sg>. Please print a hardcopy for your own reference