Allied Health Professions Council
c/o Secretariat of healthcare Professional Boards (SPB)
81 Kim Keat Road #10-00
Singapore 328836
Email: AHPC@spb.gov.sg
Website: https://www.ahpc.gov.sg

AHPC-1604-LU-04

FORM SF2
UNDERTAKING BY SUPERVISOR

INSTRUCTIONS:

1. This form is to be completed by all supervisor(s) assigned by the employer to supervise the Conditionally or Temporarily registered allied health professionals.

2. This form must be submitted to the Allied Health Professions Council (AHPC) at the time of registration application of an allied health professional with less than 1 year or no professional practice experience in Singapore; or when there is a change in the supervisor assigned by the employer.

3. Section B of this form must be acknowledged by the Head of Department.

4. The completed form must be sent to the Secretariat staff in PDF format via email.

SECTION (A) : TO BE COMPLETED BY THE SUPERVISOR

Profession:

☐ Occupational Therapist ☐ Physiotherapist ☐ Speech-Language Therapist

☐ Diagnostic Radiographer ☐ Radiation Therapist

Name of Supervisor:_____

Registration No **(if available)**:_____ Designation: _____

Institution and Department:_____

Practice Address: _____

Employment Status: ☐ Working Full time *(Minimum 40 hours per week)* ☐ Working Part time *(Please specify hours per week):* _____

Email address:_____ Contact No:_____

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)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ L3
ii.	_____ (Name)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ L3
iii.	_____ (Name)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ L3
iv.	_____ (Name)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ L3
v.	_____ (Name)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ L3
vi.	_____ (Name)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ L3
vii.	_____ (Name)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ L3
viii.	_____ (Name)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ L3
ix.	_____ (Name)	☐ Primary Supervisor ☐ Secondary supervisor	☐ Conditional / ☐ Temporary ☐ L1 / ☐ L2 / ☐ 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 Guidelines[1] 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