



COLLEGE OF FAMILY PHYSICIANS SINGAPORE

**Certificate in Community Hospital Practice
Intake 2018 – 2020**

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Passport-sized
Photograph
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APPLICATION FORM

Please ✓ the appropriate boxes accordingly. Delete where applicable.

(A) PERSONAL PARTICULARS

Family Name : _____
Given Name : _____
Nationality : Singaporean / Singapore PR / Others (please specify): _____
Sex : Male / Female Passport / NRIC No. : _____
Date of Birth : _____ (dd / mm / yyyy)
Race : Chinese / Malay / Indian / Others (please specify): _____
Residential Address : _____
Postal Code : Singapore _____
Telephone (Home) : _____ Mobile Phone No^: _____
Email Address^ : _____

(B) PRACTICE INFORMATION

MCR No : _____ Year of SMC Registration : _____
Year of Graduation : _____
Medical Registration Type : Full / Conditional / Temporary*
Practicing Status : Resident or Specialty Trainee Non-Resident
 In Service Medical Officer employed by MOHH under MOPEX & still serving bond
Type of Practice : Government NHG SingHealth NUHS
 Locum Private – Group Private – Solo Community Hospital
Practice Address : _____
Postal Code : Singapore _____
Telephone (Office) : _____ Fax (Office) : _____
Please indicate your preferred mailing address with a ✓ : Residential Address
 Practice Address

(C) COLLEGE MEMBERSHIP INFORMATION

Are you a College member : Yes No Pending Approval

*Please note that temporary registered doctors must have at least 1 year of working experience in Singapore. His/her application must also be supported by a Letter of Recommendation from his/her Head of Department.

^Mobile phone number and email address will be reflected in the CCHP Logbook. All course information pertaining to the CCHP programme will be sent via email to the provided address. Please ensure that this is the email account you would check regularly.

(D) OTHER INFORMATION

Degrees / Diplomas Awarded (Attach a separate sheet if necessary)

Qualification	Year

Job Appointments (Attach a separate sheet if necessary)

Position Held	Department Hospital / Medical Group / Practice	From (Month / Year)	To (Month / Year)	Remarks (if any)

(E) DECLARATION

- I hereby make an application for the Certificate of Community Hospital Practice and declare that all the information I have supplied on this application form is, to the best of my knowledge, complete and correct.
- I acknowledge that my application for enrolment is subjected to the admission criteria and examination eligibility as advised by College of Family Physicians Singapore.
- I further acknowledge that by signing this, I have read and agreed to abide by the Terms & Conditions as stated under "Important Notes".

Signature of the Applicant : _____ Date : _____

Please send the completed application form (with photograph attached) together with a cheque payment

(S\$2,996 for College members; S\$3,210* for non-College members)**

*made payable to 'College of Family Physicians Singapore' by **11 May 2018, Friday** to :*

College of Family Physicians Singapore

College of Medicine Building, 16 College Road #01-02, Singapore 169854

* Inclusive of 7% GST and non-refundable registration fee.

FOR OFFICIAL USE ONLY

Acknowledgement date : _____

Fee Paid : S\$ _____

Cheque / Draft No : _____

Checked by : _____

Official Receipt No : _____

Important Notes

Documents to Submit for Registration

- a) Application form
- b) 1 Passport photo
- c) Cheque payment (only accept cheque/cashier's order)
- d) Photocopy of NRIC/Employment Pass (front and back)
- e) Photocopy of GDFM certificate (for GDFM graduates)
- f) Photocopy of GDFM course acceptance letter (for GDFM trainees)

Refund Policy

- a) CFPS will charge applicant a non-refundable registration fee of \$1,070 (Inclusive of 7% GST) if the request for withdrawal from the course is made in writing latest by **30 June 2018.**
- b) Strictly no refund of fees **on or after 1st July 2018.**

Academic year commences from the day of the Commencement Ceremony on **28 July 2018.**

All feedback/correspondence related to the CCHP should be addressed to:

CCHP Programme Director

College of Family Physicians Singapore

College of Medicine Building, 16 College Road #01-02, Singapore 169854

Tel: 6223 0606

Fax: 6222 0204

Email: gdfm_ch@cfps.org.sg

Website: <http://www.cfps.org.sg>