



# COLLEGE OF FAMILY PHYSICIANS SINGAPORE

**Certificate in Community Hospital Practice  
Intake 2019 – 2021**

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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.

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) CONSENT FOR USE OF PERSONAL DATA**

I confirm and consent to College of Family Physicians Singapore (CFPS) collecting, using and/or disclosing my personal data which I have provided, including the NRIC number.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**I am applying for the Certificate in Community Hospital Practice Subsidy: Yes/No**

**If No, please complete section F below.**

**If Yes, please complete sections (F), (G) and (H) below.**

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

*made payable to 'College of Family Physicians Singapore' by **7 June 2019 (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.

### (G) DECLARATION for the Certificate in Community Hospital Practice Subsidy

1. I hereby make an application for the Certificate in Community Hospital Practice Subsidy and declare that all the information I have supplied on this application form is, to the best of my knowledge, complete and correct.
2. I acknowledge that my application for enrolment is subjected to the admission eligibility criteria for the Certificate in Community Hospital Practice programme, examination and the Certificate in Community Hospital Practice Subsidy as advised by CFPS and MOH respectively.
3. I acknowledge that by signing this, I have read and agreed to abide by the Terms & Conditions as stated under "Important Notes".
4. I declare that I do not have any disciplinary record with the SMC.

Signature of the Applicant : \_\_\_\_\_ Date : \_\_\_\_\_

*Please send the completed application form (with photograph attached) together with a cheque payment (S\$1,498\* for College members; S\$1,605\* for non-College members) made payable to 'College of Family Physicians Singapore' by **7 June 2019 (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.*

### (H) LETTER OF UNDERTAKING for the Certificate in Community Hospital Practice Subsidy

I hereby confirm my acceptance of the Terms and Conditions as spelt out by the Ministry of Health regarding the Certificate in Community Hospital Practice Subsidy as stated in the Important Notes section of this Application Form.

I affirm that all statements made by me in the application form are correct. I understand that in the event that I am unable to satisfy any one of the eligibility criteria of this Certificate in Community Hospital Practice Subsidy, I will refund the entire subsidy in accordance with the terms and conditions.

I acknowledge that the decisions of the Administrator of Certificate in Community Hospital Practice Subsidy shall be final and any appeals must be made in writing to the Administrator who will then forward it to the Ministry of Health for further consideration.

Signature of the Applicant : \_\_\_\_\_ Date : \_\_\_\_\_

#### 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 2019.**
- b) Strictly no refund of fees **on or after 1<sup>st</sup> July 2019.**

Academic year commences from the day of the Commencement Ceremony on **27 July 2019.**

## Certificate in Community Hospital Practice Subsidy

- 1) The 50% Subsidy covers:
  - Certificate in Community Hospital Practice Course Fees
- 2) Eligibility Criteria:

Doctors will need to fulfil the following requirements to be eligible for subsidy:

  - Fulfilled entry requirements for the CCHP Programme as set out by CFPS
  - Singapore Citizen or Permanent Resident
  - Accepted for the upcoming intake for the GDFM (2019-2021 intake), currently on the GDFM , or attained the GDFM within the last 5 years;
  - Full or conditional registration with the Singapore Medical Council (SMC), or temporary registration with the SMC and supported with a letter of recommendation from the head of department;
  - Good disciplinary record with SMC
  - Current and valid practicing license issued by SMC
  - Fulfilment of Continuing Medical Education (CME) requirements
  - Attempt the Certificate in Community Hospital Practice Examination (second attempt is required if first attempt is unsuccessful)
- 3) Refund Policy:

All applicants have to sign the Letter of Undertaking (see section G of this application form). Trainees who fail to fulfil the requirements under the eligibility criteria are expected to refund any subsidies provided. To claw-back the funds provided, MOHH will deduct the requisite amount from the salary of the trainee and transfer the amount to MOH. Trainees who do not receive a salary from MOHH must make a direct payment to MOH.
- 4) Applications for the subsidy are subject to internal assessment and prioritization.

**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](mailto:gdfm_ch@cfps.org.sg)

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

**All feedback / correspondence related to the MOH subsidy for Certificate in Community Hospital Practice should be addressed to:**

### **JCFMS Secretariat**

#### **Division of Graduate Medical Studies**

Yong Yoo Lin School of Medicine, National University of Singapore,

Blk MD3, Level 2, 16 Medical Drive, Singapore 117600

Tel: 6516 4261/ 6601 3734

Email: [gsmssh@nus.edu.sg](mailto:gsmssh@nus.edu.sg) / [gsmtymj@nus.edu.sg](mailto:gsmtymj@nus.edu.sg)