



# SINGAPORE MEDICAL COUNCIL

16 College Road, #01-01 College of Medicine Building, Singapore 169854  
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Notification Form No.: \_\_\_\_\_  
(for official use)

## NOTIFICATION FORM TO PERFORM LIST B OR OTHER AESTHETIC PROCEDURES

*Please use capital letters only.*

### 1. PERSONAL PARTICULARS OF DOCTOR:

FULL NAME (NRIC): \_\_\_\_\_

MCR NUMBER: \_\_\_\_\_

CLINIC'S NAME: \_\_\_\_\_

CLINIC'S ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

RESIDENTIAL ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBERS: \_\_\_\_\_(H) \_\_\_\_\_(O)

\_\_\_\_\_(HP) \_\_\_\_\_(Fax)

EMAIL ADDRESS: \_\_\_\_\_

### 2. INFORMATION ON MEDICAL MALPRACTICE INSURANCE

***Note:*** It is recommended that doctors who have been performing aesthetic procedures or intend to do so have sufficient and appropriate medical malpractice insurance to safeguard patients' interests.

NAME OF INSURANCE PROVIDER: \_\_\_\_\_

TYPE OF INSURANCE: \_\_\_\_\_

START DATE OF INSURANCE: \_\_\_\_\_

PERIOD OF INSURANCE: \_\_\_\_\_

PREMIUM AMOUNT: \_\_\_\_\_

**3. NOTIFICATION TO PERFORM LIST B OR OTHER AESTHETIC PROCEDURES**

**(A) Please tick the appropriate box(es):**

**List B**

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

- Mesotherapy
- Carboxytherapy
- Microneedling Dermaroller
- Skin Whitening Injections
- Stem Cell Activator Protein for Skin Rejuvenation
- Negative Pressure Procedures (e.g. Vacustyler)
- Mechanised Massage (e.g. "slidestyler", "endermologie" for cellulite treatment)

**(B) Other aesthetic procedure(s) (please specify):**

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**(C) Experience with the Aesthetic Procedure(s) as indicated in 3(A) and 3(B)**  
(please tick and fill in the required information accordingly)

- Yes, I have been performing the List B / Other Aesthetic Procedure(s) since \_\_\_\_\_ (dd/mm/yyyy).
- No, I am intending to provide the List B / Other Aesthetic Procedure(s) with effect from \_\_\_\_\_ (dd/mm/yyyy).

**4. DECLARATION**

I declare that the information provided in this notification form is true and authentic and herein remains unchanged to-date. To the best of my knowledge and belief, I have not withheld any material fact. I understand that my practice may be audited and that I may be required to provide more information.

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Signature and Name of Doctor

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Date

Please submit your notification form to:

Chairman  
Aesthetic Practice Oversight Committee  
Singapore Medical Council  
16 College Road #01-01  
College of Medicine Building  
Singapore 169854