



COLLEGE OF FAMILY PHYSICIANS SINGAPORE

TERMINATION OF MEMBERSHIP

Please ✓ the appropriate boxes accordingly. * Delete where applicable.

(A) PERSONAL PARTICULARS

Family Name : _____ Mobile : _____
Given Name : _____ MCR No. : _____
Email : _____
Membership Category : Fellow Collegiate Ordinary Associate Student

(B) REASONS FOR TERMINATION

Reasons for Termination : (Please Specify) _____

I, _____ hereby confirm that I would like to terminate my membership with the College of Family Physicians Singapore.

- I understand that the College will cancel any College Diploma (MCFPS &/ or FCFPS) awarded at any time to a Collegiate Member or a Fellow who ceases to be a member of the College and by a notice in writing which requires the return of any cancelled College Diploma.
- I acknowledge that I must still pay to the College all outstanding membership fees in arrears upon the termination of my membership. In the event that I do not and would like to rejoin the College, I must pay any fees in arrears owed to the College in addition to the current membership fees.

Signature of Applicant : _____ Date : _____