



COLLEGE OF FAMILY PHYSICIANS SINGAPORE

APPLICATION FOR ASSOCIATE / ORDINARY / OVERSEAS MEMBERSHIP

(Please Print or Type)

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

(A) PERSONAL PARTICULARS

Family Name : _____
 Given Name : _____
 Nationality : Singaporean / 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) : _____ Fax (Home) : _____
 Mobile Phone : _____ Pager : _____
 Email Address : _____

(B) PRACTICE INFORMATION

MCR No: _____ Please specify practising certificate type: Full / Conditional / Temporary**
 (** For temporarily registered doctors, please update the College Secretariat when you are fully or conditionally registered)
 Type of Practice : Government NHG Singhealth Private - Group Private - Solo Locum
 Practice Address : _____

 Postal Code : Singapore _____
 Telephone (Office) : _____ Fax (Office) : _____
 Please indicate your preferred mailing address with a tick ✓ : Residential Practice Address

(C) MEDICAL EDUCATION

Medical School : _____
 Degree : _____ Year of Graduation : _____
 Other Qualifications and Diplomas : (1) _____
 (2) _____
 (3) _____

Postgraduate Experience & Training :

Position Held	Hospital / Institution	Country / City	From (Month/Year)	To (Month/Year)
Housemanship				
Medical Officer				
Other Appointments				

Are you now engaged in active family practice? Please tick ✓ Yes No

Family Practice :

Position Held	Organisation	From (Month/Year)	To (Month/Year)
Assistant			
Partner			
Principal			
Trainee			
Registrar			
Associate Consultant			
Consultant / Senior Consultant			

DECLARATION

I hereby make an application for membership in the College of Family Physicians Singapore and declare that the information stated in this application are true and correct and I have not withheld/distort any facts.

I enclose the cheque numbered _____ for the amount S\$_____ (inclusive of the one-time entrance fee payment of S\$50.00).

I understand that the money will be refunded if my application is not approved.

In submitting this application, I hereby agree to abide by the regulations of the College of Family Physicians Singapore.

Signature of Applicant : _____

Date : _____

Notes

Admission to ordinary or associate membership category is based on recommendation made by the Board of Censors; subject to the approval of the College's Council.

Fees

Entrance fee : S\$ 50.00 one-time payment
Associate / Ordinary membership subscription fees : S\$180.00 per financial year (1st Apr - 31st Mar)
S\$ 90.00 per half financial year (for new members joining during 2nd half of financial year, 1st Oct - 31st Mar)
Overseas membership subscription fees : S\$ 180.00 per financial year (1st Apr - 31st Mar)

Please send the completed application form (with photograph attached) together with a cheque payment, made payable to 'College of Family Physicians Singapore' to:

The Honorary Secretary
College of Family Physicians Singapore
College of Medicine Building, 16 College Road #01-02 Singapore 169854

FOR OFFICIAL USE

Recommended for Associate / Ordinary / Overseas Membership

_____ Date

_____ Censor-in-Chief