



# SINGAPORE DENTAL COUNCIL

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

E-mail: [enquiries@dentalcouncil.gov.sg](mailto:enquiries@dentalcouncil.gov.sg)  
Tel: (65) 6372 3076/77 Fax: (65) 6221 1275

## APPLICATION FOR REGISTRATION/RESTORATION AS ORAL HEALTH THERAPIST

### Instructions to applicant:

1. Complete Parts (I) to (VII) of this application form.
2. Please submit the application along with the necessary supporting documents.
3. Please bring along the original documents for item (a), (c), (e) and (j), for verification purpose, when you come for registration at the Council's office.

	<b>DOCUMENTS TO BE SUBMITTED</b>  (must be translated into <b>English</b> if the original is in a Foreign language)	<b>REGISTRATION</b>	<b>RESTORATION</b>
(a)	Copy of the basic dental qualification (and additional qualifications, if any).	√	
(b)	Letters of verification from issuing authorities on all qualifications.	√	
(c)	Copy of the original certificate of registration/licence to practise dentistry from the Dental Council/ Licensing Authority in the last country of practice.	√	
(d)	Letter of offer of employment from prospective employer in Singapore.  For those applying for registration in Part I register, please attach proof of previous employment.	√  √	√
(e)	Copy of the current annual practising licence issued by the licensing authority in the last country of practice.	√	
(f)	Original letter of good standing from the licensing authority in the last country of practice.	√	√
(g)	Two letters of character reference from two referees who should be senior members of the teaching staff of the institution where the applicant had received his/her training <b>or</b> any two references from medical/dental professionals	√	
(h)	Certificate or letter of fitness to practice dentistry from a local Medical Practitioner. Certificate/letter to include information on current Hepatitis B* Immunisation status.	√	√
(i)	One passport-size photograph.	√	
(j)	Copy of identity card/passport.	√	
(k)	The prescribed registration/restoration fee (\$100) and practising certificate fee (\$100 for 2 years).  The prescribed fees may be paid in cash or by cheque. For payment by cheque, the cheque should be crossed and made payable to " <b>Singapore Dental Council</b> ". Please note that the registration fee is NON-REFUNDABLE.	√	√



13. Qualifications

Diploma/Certificate	Polytechnic/Institution	Year obtained			

**Part II : Registration Category**

**(I) APPLICATION FOR REGISTRATION**

14(a). I am applying for registration as:

- Dental Hygienist
- Dental Therapist
- Dental Hygienist/Dental Therapist

14(b). To be registered under:

- Part I of the register of OHT

To register under Part I of register, please provide your work history for the last 5 years or more [please attach proof(s) of employment]:

From (dd/mm/yy)	To (dd/mm/yy)	Name and address of dental clinic/institution	Provide name of dentist working under (must be a Div I dentist)

*(Additional information may be attached to the application if space is insufficient)*

- Part II of the register of OHT

**Part III : PARTICULARS OF PRACTICE**

**PLACE OF PRACTICE**

15 (a) EMPLOYMENT SECTOR

- Public       Restructured  
Institutions       Academia       Statutory  
Board       Private

15 (b) EMPLOYMENT TYPE

- Full-time       Part-time (working less than 30 hours per week)

16 (a) If you are taking up an appointment in the public sector/restructured institution/academia/statutory board:



your fitness to practise as a Oral Health Therapist?

Yes

No

23. Have you ever suffered from Hepatitis B or other infectious diseases?

Yes

No

*If you have answered "Yes" to any of questions 18 to 21, please provide further details in a separate document.*

I declare that the particulars stated in this application and the documents attached are true to the best of my knowledge and belief, and I have not wilfully suppressed any material fact.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

**Part V : CERTIFICATION**

**CERTIFICATE OF IDENTITY** – to be completed by a registered dentist (whose name appears in the first division of the Dentists Register), or a medical practitioner registered in Singapore under the Medical Registration Act (Cap 174), or a Magistrate, or a Justice of the Peace.

I hereby certify that (name of applicant) \_\_\_\_\_ is known to me personally and I support his/her application to be registered to practise dentistry in Singapore.

\_\_\_\_\_  
Name of dentist/doctor/Magistrate/JP

\_\_\_\_\_  
Registration No./Seal of Office

\_\_\_\_\_  
Signature & Date

**CERTIFICATE OF FITNESS TO PRACTISE DENTISTRY** - to be completed by a medical practitioner registered in Singapore under the Medical Registration Act (Cap 174)

I, Dr \_\_\_\_\_

of (name of clinic) \_\_\_\_\_

Certify that I have examined (name of Oral Health Therapist applying for registration)

\_\_\_\_\_

and that in my opinion, he/she is both physically and mentally fit to practise dentistry.

Signature of medical practitioner \_\_\_\_\_

Qualification(s) \_\_\_\_\_

SMC Reg No \_\_\_\_\_

Date \_\_\_\_\_

Stamp of medical clinic

