



SINGAPORE DENTAL COUNCIL

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

E-mail: enquiries@dentalcouncil.gov.sg
Tel: (65) 6355 2400/01 Fax: (65) 6253 3185

APPLICATION FOR REGISTRATION AS DENTIST (for dentists who are converting from Conditional to Full Registration)

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 document for item (d), for verification purpose, when you come for registration at the Council's office.

	DOCUMENTS TO BE SUBMITTED (must be translated into English if the original is in a Foreign language)	CONVERSION TO FULL REGISTRATION
(a)	Curriculum vitae (including postgraduate experience and testimonials on postgraduate experience or names and addresses of referees).	√
(b)	Covering letter of application for full registration	√
(c)	One passport-size photograph.	√
(d)	Copy of identity card/passport.	√
(e)	The prescribed registration fee (\$200).	√
(f)	The pro-rated practising certificate fee (\$400 for 2 years) to be charged, where applicable. The prescribed fee(s) may be paid in cash or by cheque. For payment by cheque, the cheque should be crossed and made payable to " Singapore Dental Council ". Please note that the registration fee is NON-REFUNDABLE.	√

(III) QUALIFICATIONS OF APPLICANT

14. GRADUATE AND POST GRADUATE QUALIFICATION(S)

14(a). Basic Degree	University/College	Year			
14(b). Post Basic Degree(s)	University/College	Year			

(IV) PARTICULARS 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)

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

Date joined/joining:	Type of appointment:	Type of work:
Appointment grade/title:	<input type="checkbox"/> Permanent <input type="checkbox"/> Contract <input type="checkbox"/> Temporary	<input type="checkbox"/> Clinical <input type="checkbox"/> Teaching/research <input type="checkbox"/> Others (pls specify): _____ Dental Specialty (if applicable): _____

15 (d) If you are going into the private sector:

<input type="checkbox"/> Dentist in individual practice <input type="checkbox"/> Dentist in group practice <input type="checkbox"/> Employment in private hospital <input type="checkbox"/> Locum	<input type="checkbox"/> Others (pls specify): _____ Dental Specialty (if applicable): _____
--	---

16. Address of Main practice:

Name of clinic

Block/House No Level Unit Number Street/Road

Street/Road

Name of Building (if any)

Postal Code Telephone Fax Number

L&A Unit Licence No. Date of issue of licence

(VII) CERTIFICATE OF FITNESS TO PRACTISE - 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 dentist 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

For Official Use

NRIC/ FIN											Date of Registration											DCR No.																	
Registered under <input type="checkbox"/> Full registration															<u>Previous records</u> Conditional Registration from _____ to _____ (dd/mm/yy) (dd/mm/yy)																								
Registrar's Approval/Comments*																																							
_____ Signature/Date																																							
<input type="checkbox"/> Cash <input type="checkbox"/> Cheque Bank: _____ Cheque Number: _____ <input type="checkbox"/> Others: _____															Registration Fee: \$ _____										Receipt Number: _____ Date of Receipt: _____														
															Practising Certificate Fee: Yes/No * • If yes, please state \$ _____ • If no, please state end-date of current practising certificate _____ (dd/mm/yy)										Receipt Number: _____ Date of Receipt: _____														
Total amount: collected \$ _____																																							

*Delete, where appropriate