SINGAPORE MEDICAL COUNCIL
16 College Road, #01-01 College of Medicine Building, Singapore 169854
General Enquiries: (65) 6372-3061/2/3/4/5 CME Hotline: (65) 6372-3060
Fax Number: (65) 6221-0558
E-mail Address: moh_smc@moh.gov.sg

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: ____________________

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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

- ☐ 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.

________________________________   ____________________

Signature and Name of Doctor   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