



# ACADEMY OF MEDICINE, SINGAPORE

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## PARTICULARS UPDATE FORM

PLEASE PRINT or WRITE CLEARLY

RETURN TO ACADEMY OF MEDICINE BY FAX OR EMAIL AT:  
 Email: membership@ams.edu.sg or Fax: (65) 6593 7880

Kindly complete all fields below in **BLOCK LETTERS** (except for email address).

PERSONAL DETAILS	
Full Name (underline <u>surname</u> ):	
MCR/DCR No.:	NRIC/Passport No.(foreigner):
Date of Birth:	Nationality:
CONTACT DETAILS	
Mobile No.:	Office No.:
Home No.:	Fax No.:
Email Address:	Name of Institution/ Place of Practice:
Home Address: (tick <input type="checkbox"/> if this is your postal address)	Practice Address: (tick <input type="checkbox"/> if this is your postal address)
Postal Code:	Postal Code:
Signature:	Date:
REGISTERED SPECIALTY WITH SAB / SMC (please tick <input checked="" type="checkbox"/> )	
<input type="checkbox"/> Anaesthesiology <input type="checkbox"/> Cardiology <input type="checkbox"/> Cardiothoracic Surgery <input type="checkbox"/> Dermatology <input type="checkbox"/> Diagnostic Radiology <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> General Surgery <input type="checkbox"/> Geriatric Medicine <input type="checkbox"/> Haematology <input type="checkbox"/> Hand Surgery	<input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Neurology <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Obstetrics & Gynaecology <input type="checkbox"/> Occupational Medicine <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopaedic Surgery <input type="checkbox"/> Otorhinolaryngology <input type="checkbox"/> Paediatric Medicine
<input type="checkbox"/> Paediatric Surgery <input type="checkbox"/> Palliative Medicine <input type="checkbox"/> Pathology <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Psychiatry <input type="checkbox"/> Public Health Medicine <input type="checkbox"/> Rehabilitation Medicine <input type="checkbox"/> Renal Medicine <input type="checkbox"/> Respiratory Medicine <input type="checkbox"/> Rheumatology <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Urology	<b>Dental Specialties</b> <input type="checkbox"/> Endodontics <input type="checkbox"/> Oral & Maxillofacial Surgery <input type="checkbox"/> Orthodontics <input type="checkbox"/> Paediatric Dentistry <input type="checkbox"/> Periodontology <input type="checkbox"/> Prosthodontics
For Official Use Only:	
Date received:	Received by:
Remarks:	