

CLINICAL FELLOWSHIP/ OBSERVERSHIP APPLICATION FORM

Note

- All sections should be completed. For items which are not applicable, please state NA.
- An administrative fee of SGD 153 is applicable for observership application and SGD 509 for fellowship application.
- True copies certificates of academic and professional qualifications, testimonials, CVs etc will need to be presented upon request.
- Please note upon successful fellowship application with the Institute of Mental Health, you will be given a conditional offer. This offer will only be confirmed upon successful application for the necessary medical registration, training pass, visa, medical examinations and completion of all necessary administrative procedures with Singapore Medical Council and Ministry of Manpower etc.
- **Successful applicants are not eligible for reimbursements or benefits. Observership/Fellowship is self-funded or in accordance to Singapore Medical Council criteria. Sponsorship from IMH is not available.**
- **All costs (application, administrative, accommodation, flights etc) will be borne by applicant or their sponsor.**
- **The main objective of observership/fellowship programme is for candidates to gain exposure in the Singapore healthcare industry and/ or learn specific clinical skills. Successful completion of the programmes is evidence of experience gained but not competency achieved. Completion of the observership or fellowship programme does not imply any recognition or acceptance for registration with any local or overseas medical council/ examination board/ medical association.**

1) APPLICANT PARTICULARS

Personal Particulars		
Full Name (as shown in passport)	Family Name	Gender ☐ Male ☐ Female
Date of Birth (DD/MM/YYYY)	Age	NRIC/Passport No*
Nationality	Country of Residence	
Contact Details		
Email Address		
Home Address		
Corresponding Address		
Contact No		
Emergency Contact Person		
Name	Relationship	Contact No
Language Proficiency		
English	Spoken ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Written ☐ Excellent ☐ Good ☐ Fair ☐ Poor

*Delete where applicable.

2) APPLICATION INFORMATION

Specialty/ Training Department ☐ Medical ☐ Allied Health ☐ Nursing	Subspeciality
☐ Fellowship (max 1 year) ☐ Observership (max 28 days)	
Duration Fellowship – 6 / 9 / 12 months / others: Observership – 1 / 2 / 4 weeks / others:	Preferred Commencement Date
Funding ☐ Self-funded (no funding from institution/funding body) ☐ Sponsored by Institution/Funding Body Please state name of Institution/Funding Body: _____	
Training Objectives	
Skills/Techniques/Procedures	
Reasons for application	

3) CURRENT JOB INFORMATION

Name of current/last Employer	From (MM/YYYY)	To (MM/YYYY)
Department	Current Job Title	
Description of Role and Responsibility		
Sector ☐ Public/Government ☐ Private ☐ Others: _____		
Hospital/Institution Address		
Name of Head of Department	Email of Head of Department (Institution email)	

*Delete where applicable.

EDO005/F01/R02

4) EDUCATION/TRAINING DEVELOPMENT

Basic Degree (MBBS or others)

From (DD/MM/YYYY)	To (DD/MM/YYYY)	Conferring Institution/Country	Qualification Attained
Language of Instruction: English / Others *			
If others, please state: _____			

Postgraduate Qualification (MMed, FRCS, Other Degrees/Fellowships or equivalent)

From (DD/MM/YYYY)	To (DD/MM/YYYY)	Conferring Institution/Country	Qualification Attained

Housemanship/Internship posting (After completion of basic medical degree)

From (DD/MM/YYYY)	To (DD/MM/YYYY)	Appointment	Department /Institution	Country

Other Residency/Postgraduate Appointments (between houseman/internship postings and the current position)

From (DD/MM/YYYY)	To (DD/MM/YYYY)	Appointment	Department/Institution	Country

Clinical Experience

--

*Delete where applicable.

5) EMPLOYMENT HISTORY

Please list your employment history starting with the most current place of practice.

From (DD/MM/YYYY)	To (DD/MM/YYYY)	Position Held	Department/Institution	Country

6) PUBLICATIONS

Journal	Article Name	Co-Authors	Date of Publication

7) PROFESSIONAL MEMBERSHIP & LICENSE

Date of membership (MM/YYYY)	Institution/Country	Membership Type/Post held
Date of license (MM/YYYY)	Conferring Institution/Country	
Professional Interest, Achievements and Plans for the future		

8) PROFESSIONAL REFERENCES

Reference 1	
Name	Designation
Institution Name	
Institution Address	
Email	
Reference 2	
Name	Designation
Institution Name	
Institution Address	
Email	

9) DECLARATION BY APPLICANT

Have you confirmed a clinical/ teaching position with an institution in your country upon completion of the training program in Singapore (YES/ NO)*	
Have you applied for any fellowship program in Singapore (YES/ NO)*	
By signing this form, you agree that Institute of Mental Health may collect, use and disclose your personal data, as provided in this form, or (if applicable) obtained by our organisation as a result of your training here, for the following purpose in accordance with the Personal Data Protection Act and our data protection policy: (a) the processing of registration; (b) and the administration of the programme. You have the right to revoke this authorization at any time, provided you do so in writing. However, please note that withdrawal of consent is equivalent to withdrawal from the training programme. I understand that any false statement made by me on this application or any supplement thereto will be sufficient ground for disqualification or termination if I am appointed. The willful suppression of any material fact will be similarly penalized.	
Applicant's Signature:	Application Date:

*Delete where applicable.