Singapore National Eye Centre
SingHealth
www.snec.com.sg

Photograph

11 Third Hospital Avenue
Singapore 168751
Tel: (65) 62277255 (23 Lines)
Facsimile: (65) 62277290
Email: trainingandeducation@snec.com.sg
Website: www.snec.com.sg

APPLICATION FOR SNEC OBSERVERSHIP (HANDS-OFF BASIS) IN:

- Cataract & General Ophthalmology
- Cornea and External Eye Diseases
- Glaucoma
- Medical Retina
- Neuro-Ophthalmology
- Oculoplastic
- Ocular Inflammation & Immunology
- Paediatric Ophthalmology & Strabismus
- Surgical Retina

Period of Observership: _____

INSTRUCTIONS

Please read the instructions carefully before completing the form.

i) All sections are to be neatly completed. If not applicable, indicate "NA". If space provided is not sufficient, please attach separate sheet.

ii) Please enclose a list of your surgical experience.

iii) Please enclose copies of your basic and post-graduate educational certificates, current valid medical registration license, current valid medical malpractice insurance and a passport-sized photograph.

iv) The duly completed application form, accompanying documents & photograph to be submitted as a softcopy via email to trainingandeducation@snec.com.sg

v) For successful applications, an administrative fee of SGD 160.50 non-refundable (inclusive of GST) is to be paid when accepting the offer.

1. PERSONAL PARTICULARS

Name : _____Passport No: _____
(Underline family name or surname)

Home Address: _____

_____

_____Country:_____

Postal Address: _____

_____

_____Country: _____

Tel (Office) : _____ Residence or Mobile No.: _____

Fax Number : _____ E-mail Address: _____

Date of Birth : _____ Age : _____ Nationality: _____

2. PRE-MEDICAL EDUCATION

From	To	Name of School/College	Country	Qualification Attained

3. MEDICAL SCHOOL BASIC DEGREE

From	To	Name of Medical School	Country	Qualifications Attained

4. OTHER DEGREES/HONOURS/FELLOWSHIPS

From	To	Name of Institution	Country	Qualifications Attained or Specialty

5. HOUSEMANSHIPS

From	To	Name of Institution	Country	Specialty

6. RESIDENCIES

From	To	Name of Institution	Country	Specialty

7. POSTGRADUATE COURSES

From	To	Name of Medical School or Other Sponsoring Body	Country	Specialty or Subject

8. PAST AND PRESENT APPOINTMENTS AND PROFESSIONAL EXPERIENCE (INSTITUTIONAL & PRIVATE)

From	To	Name of Hospital	Country	Medical Staff Position

9. PAST AND PRESENT TEACHING POSITIONS (IF APPLICABLE)

From	To	Name of Medical School or Institution	Country	Faculty Position and Department

10. PERCENTAGE OF PRACTICE: GENERAL OPHTHALMOLOGY/SUB-SPECIALTIES

Name of Sub-specialty Field	Percentage of Work in Special Field
	%
	%
	%

11. PROFESSIONAL MEMBERSHIPS

Date	Journal	Title/Co-Authors

12. PUBLICATIONS (ATTACH SEPARATE SHEET IF NECESSARY)

Date	Journal	Title/Co-Authors

13. LIST ATTENDANCE AT REGIONAL/INTERNATIONAL SCIENTIFIC MEETINGS AND INDICATE IF PRESENTED PAPERS OR CO-ORDINATED/CHAIRED SESSIONS

Year	Name of Meeting	If Presented Papers, Posters or co-ordinated sessions, please give details

14. 3 REFEREES*

Full Name	Address, Fax No. and Email Address	Designation, Institution & Country of Work

**** Referees should either be department heads or direct supervisors who are familiar with your work.***

15. MEDICAL INSURANCE

Type	Valid Period	Registration No.

16. PLEASE GIVE BELOW ANY OTHER INFORMATION YOU FEEL IS RELEVANT TO YOUR APPLICATION.

_____

_____

_____

17. DECLARATION

I declare that the information given in the application is true to the best of my knowledge and that I have not wilfully suppressed any material fact.

_____ _____

Date Signature of Applicant