## SGH LOCAL FELLOWSHIP Application Form

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| **SECTION A: APPLICANT’S PARTICULARS** |
| **Applicant Full Name as in NRIC** (underline family name) | Choose a Salutation | Click here to enter text |
| **Employing Institution** | Click here to enter text | Please affix your latest coloured and high resolutionphoto here |
| **Department / Unit**  | Click here to enter text |
| **Specialty**  | Click here to enter text |
| **Sub-specialty**  | Click here to enter text |
| **Job Title** | Click here to enter text |
| **Email Address** | Click here to enter text |
| **Mobile Number** | Click here to enter text |

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| **SECTION B: TRAINING REQUEST** |
| **SGH Local Fellowship Programme Applying For** | Click here to type in title of local HMDP/ Fellowship programme |
| **Duration of Training** (in terms of months) | Click here to enter text months |
| **Requested Training Period** | **Start Date** (dd/mm/yyyy) : |  | **End Date** (dd/mm/yyyy) : |  |
| **Your Training Objectives**(please attach a separate sheet if necessary) | 1. Click here to enter text2. Click here to enter text3. Click here to enter text4. Click here to enter text |
| **Focus Area**Please outline the new skills to be acquired in your training and what are the "hands-on" clinical skills/training you need to acquire from the training to meet your objective. | Click here to enter text |
| **Training Sponsor** | [ ]  Applying for MOH HMDP grant call year click here to enter year of grant call applying to [ ]  Employing institution sponsored |

**Please furnish a supporting letter from your institution and your up-to-date CV, together with your application submission.**

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| **SECTION C: DECLARATION BY APPLICANT** |
| I hereby certify that the information given in this application is true, accurate and complete to the best of my knowledge. In addition, I hereby authorise the disclosure and use of any of my personal information by my employer for matters related to this application. I shall not hold Singapore General Hospital or any of its representatives or staff responsible for the disclosure and use of my personal information and medical records for matters related to this application. |
| Signature of Applicant : |   |  | Date: | Click here to enter a date. |

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| **FOR SGH’S OFFICIAL USE ONLY** |

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| Signature & Name Stamp of Assigned Clinical Supervisor Date: Click here to enter a date.  | Signature & Name Stamp of Clinical Head/Director Date: Click here to enter a date. |
| If rejected, please state reason(s): Click or tap here to enter text. |