Registration Form

Clinic Assistant Introductory Skills Course (3rd to 6th July 2019 Intake)

Participant's Particulars

Name (in CAP)_____

NRIC (last 3 digits + alphabet) SXXXX_____

DOB:_____ Age: _____ Gender: Male / Female

Home Address: _____

_____

Tel: _____ Mobile: _____

Email: _____

Highest Academic Qualifications:

Completed/Passed* Sec __ / N Level / O Level/ Others_____

Designation: __Clinic Assistant_____

Start date with Clinic: _____ (DD/MM/YYYY)

Status: Full- time / Part-time / Working Hours: From _____ / am/pm

to _____am/pm . Mon/Tue/Wed/Thu/Fri/Sat/Sun _____

Company Details

Name of Doctor (in full)Dr _____

SMA Member: Yes / No

Clinic Name: _____

Address: _____

_____ Postal Code _____

Tel: _____ Fax: _____

Email: _____

Contact Person: _____

Designation: _____

Date : _____ Signature with Company stamp : _____

Please mail cheque to "Singapore Medical Association Pte Ltd"

Address: 2958 Jalan Bukit Merah, #02-2C, SMF Building, Singapore 159457

Tel: 62231264 Fax: 6252 9693 Email: placeandtrain@sma.org.sg

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