

**MASTER OF PUBLIC HEALTH COURSE APPLICATION FORM**

Course of Study: [Please tick accordingly]

- Part Time
- Full Time

Passport-sized  
Photo

Track Applied for: [Please tick accordingly]

- General Public Health
- Clinical Epidemiology
- Global Health
- Occupational & Environmental Health

**A) PERSONAL PARTICULARS (PLEASE WRITE IN BLOCK LETTERS)**

1. NAME \_\_\_\_\_ (Dr / Mr / Mrs / Miss / Mdm) \*  
 (Please underline Surname / Family Name)

2. PASSPORT/NRIC NO \_\_\_\_\_ 3. DATE OF BIRTH \_\_\_\_\_ (dd/mm/yyyy)

4. TYPE OF NRIC : S'pore Pink/S'pore Blue/M'sia Blue/M'sia Pink /Others\* \_\_\_\_\_ (Please specify)

5. HOME/PERMANENT ADDRESS

\_\_\_\_\_

\_\_\_\_\_

6. MAILING ADDRESS (if different from above. Please do not give P.O.Box address)

\_\_\_\_\_

\_\_\_\_\_

7. TEL NO \_\_\_\_\_ 8. HANDPHONE NO \_\_\_\_\_ 9. PAGER NO \_\_\_\_\_

10. FAX NO \_\_\_\_\_ 11. EMAIL \_\_\_\_\_

12. RACE : Chinese/Malay/Indian/Others\* \_\_\_\_\_ (please specify)

13. SEX: Female/Male\* 14. MARITAL STATUS : Single/Married/Divorced/Widowed\*

15. DOMICILE (DOM) / PLACE OF BIRTH (POB) [Please tick accordingly]

COUNTRY	DOM	POB
Singapore	<input type="checkbox"/>	<input type="checkbox"/>
Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>

16. CITIZENSHIP ( Non –Singaporeans please indicate if you also a Singapore PR) [Please tick accordingly]

Singapore	<input type="checkbox"/>	Singapore PR	<input type="checkbox"/>	Malaysia	<input type="checkbox"/>	Brunei	<input type="checkbox"/>
Bangladesh	<input type="checkbox"/>	India	<input type="checkbox"/>	China	<input type="checkbox"/>	Myanmar	<input type="checkbox"/>
Pakistan	<input type="checkbox"/>	Philippines	<input type="checkbox"/>	Indonesia	<input type="checkbox"/>	Sri Lanka	<input type="checkbox"/>
Others	<input type="checkbox"/>	_____ (please specify)					

17. **NATIONAL SERVICE** : Completed / Disrupted / Currently Serving/ Exempted/ Not Applicable\*  
Please specify (expected) ORD, if applicable \_\_\_\_\_

**B) ACADEMIC QUALIFICATIONS**

**1. SECONDARY EDUCATION**

From	To	Name of School / Country	Qualification obtained
_____	_____	_____	_____
_____	_____	_____	_____

**2. ACADEMIC QUALIFICATIONS (Please attach transcripts of each qualification)**

Tertiary qualification (s)	Date Passed (dd/mm/yy)	Institution(s) / Country
_____	_____	_____
_____	_____	_____
_____	_____	_____
Advanced Diploma qualification(s)	Date Passed (dd/mm/yy)	Institution(s) / Country
_____	_____	_____
_____	_____	_____
Postgraduate Qualification (s)	Date Passed (dd/mm/yy)	Institution(s) / Country
_____	_____	_____
_____	_____	_____
Other Higher Degree (s)	Date Passed (dd/mm/yy)	Institution(s) / Country
_____	_____	_____
_____	_____	_____

**3. REGISTRATION AS LEGALLY QUALIFIED MEDICAL PRACTITIONER (for medical applicants)**

Country : \_\_\_\_\_ Year of Registration: \_\_\_\_\_

**4. TOEFL Score obtained :** \_\_\_\_\_ **OR IELTS score obtained:** \_\_\_\_\_  
(Applicable only to international applicants whose native tongue or medium of undergraduate instruction is not English)

**(C) PERSONAL STATEMENT**

**Please attach a brief statement (approximately 1 page) on a separate sheet, to include the following:**

- Your current role in Public Health / Clinical Research / Global Health / Occupational and Environmental Health
- The relevance of this course to your work
- Your goals after the completion of this course

**(D) WORKING EXPERIENCE**

**1. Current position**

Designation: _____	From: _____	To: _____
	(dd/mm/yyyy)	(dd/mm/yyyy)
Name of Hospital/ Institution & Dept: _____		
Mailing address: _____		
_____		
Country: _____	Name of Head of Dept: _____	
Brief Job description: _____		

**2. Previous working experience (in chronological order, starting from the most recent)**

Designation: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy)

Name of Hospital/ Institution & Dept: \_\_\_\_\_

Country: \_\_\_\_\_ Name of Head of Dept: \_\_\_\_\_

Brief Job description: \_\_\_\_\_  
\_\_\_\_\_

Designation: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy)

Name of Hospital/ Institution & Dept: \_\_\_\_\_

Country: \_\_\_\_\_ Name of Head of Dept: \_\_\_\_\_

Brief Job description: \_\_\_\_\_  
\_\_\_\_\_

Designation: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy)

Name of Hospital/ Institution & Dept: \_\_\_\_\_

Country: \_\_\_\_\_ Name of Head of Dept: \_\_\_\_\_

Brief Job description: \_\_\_\_\_  
\_\_\_\_\_

**(E) PREVIOUS APPLICATIONS**

- I am applying to enter this programme for the 1<sup>st</sup> time.  
 Yes  No (If no, please state the year of previous attempts: \_\_\_\_\_)
- Have you previously applied for admission or been admitted to any postgraduate coursework program(s) in NUS?  
 Yes  No (If yes, please state program applied for: \_\_\_\_\_)  
Year of application : \_\_\_\_\_ Outcome of application: Successful / Unsuccessful \*  
Date of Enrolment : From \_\_\_\_\_ To \_\_\_\_\_ Current Status: Graduated/Withdrawn/ Failed/Student\*
- Are you applying for any other postgraduate program at NUS for the coming session?  
 Yes  No (If yes, please state program applied for: \_\_\_\_\_)

**(F) SOURCE OF FINANCE**

- Source of Finance: Self-Support / Sponsorship / Others\* (Please specify \_\_\_\_\_)
- Please refer to Para 4 of the application instructions (Graduate Scholarships) before filling in the following:
- a) I wish to be considered for a Graduate Scholarship:  Yes  No (If No, please continue to Section (G))  
b) Source of funding for accommodation and other living expenses: Self- Support / Company or Institutional sponsorship / Others \* (Please specify \_\_\_\_\_)

**Note: Please attach documentary evidence of financial support for these expenses, e.g. letter of sponsorship (individual or organization).**

**(G) PARTICULARS OF NEXT-OF-KIN**

1 Full Name (Mr/Mrs/Miss/Mdm\*) \_\_\_\_\_ 2. Relationship: \_\_\_\_\_  
3. Occupation: \_\_\_\_\_ 4. Email: \_\_\_\_\_  
5. Tel No.: \_\_\_\_\_ 6. Mobile No.: \_\_\_\_\_  
6. Home Address : \_\_\_\_\_  
\_\_\_\_\_

**(H) DECLARATION**

*I affirm that all statements made by me on this form are correct. I understand that any inaccurate or false information (or omission of material information) will render this application invalid and that, if admitted on the basis on such information, I may be required to withdraw from the University.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Please send completed application form together with cheque / bank draft made payable to  
"National University of Singapore" to

**Attn: Course Administrator, Master of Public Health  
Division of Graduate Medical Studies  
Yong Loo Lin School of Medicine  
National University of Singapore  
MD5, Level 3, 12 Medical Drive  
Singapore 117598**

**FOR OFFICIAL USE ONLY**

1. SERIAL NO.: \_\_\_\_\_ 2. DATE RECEIVED: \_\_\_\_\_  
3. FORM RECEIVED BY: \_\_\_\_\_ 4. CASH/CHEQUE/DRAFT NO.: \_\_\_\_\_  
5. FEE PAID: S\$ \_\_\_\_\_ 6. OFFICIAL RECEIPT NO.: \_\_\_\_\_  
7. DATA ENTERED BY: \_\_\_\_\_ 8. DATA ENTERED ON (DATE): \_\_\_\_\_

REMARKS (If any):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_