

**Examination Application Form for 2009 Final (M.Med) (Int. Med) PACES Exam (26 to 30 Jun 09)**

**(A) PERSONAL PARTICULARS**

1. **FULL NAME** : (Mr/Mrs/Miss/Mdm/Ms) \_\_\_\_\_  
 (Please underline family name)

**NAME TO BE REFLECTED ON DEGREE SCROLL**: (if different from above)  
 \_\_\_\_\_

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

4. **TYPE OF NRIC** : Singapore Pink/Singapore Blue/Malaysia Blue/Malaysia Pink\*

5. **HOME/PERMANENT ADDRESS**  
 \_\_\_\_\_  
 \_\_\_\_\_

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

7. **TEL NO** \_\_\_\_\_ 8. **PAGER NO** \_\_\_\_\_ 9. **FAX NO** \_\_\_\_\_

10. **HANDPHONE NO** \_\_\_\_\_ 11. **EMAIL** \_\_\_\_\_

12. **RACE** : Chinese/Malay/Indian/Others\* \_\_\_\_\_ (please specify) 13. **SEX** : Female/Male\*

14. **MARITAL STATUS** : Single/Married/Divorced/Widowed\*

15. **COUNTRY OF RESIDENCE(COR)/ OF BIRTH (COB)**

	<b>COR</b>	<b>COB</b>		<b>COR</b>	<b>COB</b>
Singapore	<input type="checkbox"/>	<input type="checkbox"/>	Brunei	<input type="checkbox"/>	<input type="checkbox"/>
West Malaysia	<input type="checkbox"/>	<input type="checkbox"/>	Others	<input type="checkbox"/>	<input type="checkbox"/>
East Malaysia	<input type="checkbox"/>	<input type="checkbox"/>	Please specify _____		

\* Please delete where not appropriate

**16. CITIZENSHIP ( Non –Singaporeans have to indicate whether they are also Singapore PR)**

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)					

**(B) ACADEMIC QUALIFICATION**

**1. TERTIARY EDUCATION (UNDERGRADUATE)**

<u>From</u>	<u>To</u>	<u>Name and Location of University</u>	<u>Certificate</u>
_____	_____	_____	_____
_____	_____	_____	_____

**2. POSTGRADUATE EXAMS & PROFESSIONAL QUALIFICATION OBTAINED**

_____	_____	_____
Institution of Award	Name of Exam	Date passed (dd/mm/yy)
_____	_____	_____
Institution of Award	Name of Exam	Date passed (dd/mm/yy)

**3. MEMBERSHIP OF PROFESSIONAL ORGANISATIONS**

<u>From</u>	<u>To</u>	<u>Organisation</u>	<u>Post Held/Membership Status</u>
_____	_____	_____	_____
_____	_____	_____	_____

**4. REGISTRATION AS LEGALLY QUALIFIED MEDICAL PRACTITIONER**

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

**(C) WORKING EXPERIENCE**

**1. HOSPITAL POSTINGS (IN CHRONOLOGICAL ORDER, STARTING FROM POST-HOUSEMAN YEAR. FOR LOCAL CANDIDATES, to include national service postings and start of MOH Basic Traineeship posting.)**

i) Appointment: \_\_\_\_\_ ii) Appointment: \_\_\_\_\_  
From: \_\_\_\_\_ to \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy) (dd/mm/yyyy) (dd/mm/yyyy)  
Unit/Hospital: \_\_\_\_\_ Unit/Hospital: \_\_\_\_\_  
\_\_\_\_\_  
No. of Beds: \_\_\_\_\_ No. of Beds: \_\_\_\_\_  
\_\_\_\_\_  
Name of Head of Dept: \_\_\_\_\_ Name of Head of Dept: \_\_\_\_\_

iii) Appointment: \_\_\_\_\_ iv) Appointment: \_\_\_\_\_  
From: \_\_\_\_\_ to \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy) (dd/mm/yyyy) (dd/mm/yyyy)  
Unit/Hospital: \_\_\_\_\_ Unit/Hospital: \_\_\_\_\_  
\_\_\_\_\_  
No. of Beds: \_\_\_\_\_ No. of Beds: \_\_\_\_\_  
\_\_\_\_\_  
Name of Head of Dept: \_\_\_\_\_ Name of Head of Dept: \_\_\_\_\_

v) Appointment: \_\_\_\_\_ vi) Appointment: \_\_\_\_\_  
From: \_\_\_\_\_ to \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy) (dd/mm/yyyy) (dd/mm/yyyy)  
Unit/Hospital: \_\_\_\_\_ Unit/Hospital: \_\_\_\_\_  
\_\_\_\_\_  
No. of Beds: \_\_\_\_\_ No. of Beds: \_\_\_\_\_  
\_\_\_\_\_  
Name of Head of Dept: \_\_\_\_\_ Name of Head of Dept: \_\_\_\_\_

vii) Appointment: \_\_\_\_\_ viii) Appointment: \_\_\_\_\_  
From: \_\_\_\_\_ to \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_  
(dd/mm/yyyy) (dd/mm/yyyy) (dd/mm/yyyy) (dd/mm/yyyy)  
Unit/Hospital: \_\_\_\_\_ Unit/Hospital: \_\_\_\_\_  
\_\_\_\_\_  
No. of Beds: \_\_\_\_\_ No. of Beds: \_\_\_\_\_  
\_\_\_\_\_  
Name of Head of Dept: \_\_\_\_\_ Name of Head of Dept: \_\_\_\_\_

**2. OTHER NON-MEDICAL POSITIONS HELD**

Please list, in chronological order (starting current positions, the positions you have held after obtaining your bachelor's degree. Attach separate sheet if necessary. **Note: For full-time NUS staff, please indicate staff no).**

From	To	Name & Location of Firm (indicate Department)	Title/Position	Nature of Work

**3. NATIONAL SERVICE : Completed/Disrupted/Currently Serving/Exempted/Not applicable\***

*Please specify (expected) ORD, if applicable \_\_\_\_\_*

**(D) PREVIOUS APPLICATIONS**

1. I am applying to sit this examination for the first time:

Yes  No  *If no, please state the year of previous attempts: \_\_\_\_\_*

2. Have you previously applied for admission or been admitted to any postgraduate coursework programme(s) or examination(s) at NUS ?

Yes  No  *If yes, please state programme applied for : \_\_\_\_\_*

*Year of application : \_\_\_\_\_ Outcome of application : Successful/Unsuccessful\**

*Date of Enrolment : From \_\_\_\_\_ to \_\_\_\_\_ Current Status : Graduated/Withdrawn/Failed/Student\**

3. Are you applying for any other postgraduate coursework programme or examination at NUS for the coming session ?

Yes  No  *If yes, please state programme applying for : \_\_\_\_\_*

**(E) SOURCE OF FINANCE**

1. Source of Finance : Company Sponsorship/Self-Support/Others\* (Please specify \_\_\_\_\_)

\* Please delete where not appropriate

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

1. FAMILY NAME \_\_\_\_\_ GIVEN NAME \_\_\_\_\_  
(Mr/Mrs/Miss/Mdm) \*

2. RELATIONSHIP \_\_\_\_\_ 3. OCCUPATION \_\_\_\_\_

4. TEL/PAGER NO \_\_\_\_\_ 5. EMAIL \_\_\_\_\_

6. HOME/PERMANENT ADDRESS  
\_\_\_\_\_  
\_\_\_\_\_

**(G) 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 can be required to withdraw from the University.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

\* Please delete where not appropriate

**Please send your completed application form together with the required payment before the closing date to the following:**

**(Final M.Med/ MRCP (PACES) Exam Application)  
Division of Graduate Medical Studies, Yong Loo Lin School of Medicine  
MD5 Level 3, 12 Medical Drive, NUS  
Singapore 117598**

**Tel: (65) 6516 3311/ 7957/ 3300**

**Fax: (65) 6773 1462**

For Official Use	
Fees Paid	: S\$ _____
Cheque/ Draft No.	: _____
Official Receipt No.	: _____
Date of Receipt Issued	: _____
Acknowledged by	: _____

