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## **EXAMINATION APPLICATION FORM**

**Examination applying for:** 2010 Primary M.Med (Internal Medicine) Written Exam

### **(A) PERSONAL PARTICULARS**

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

\* Please delete where not appropriate

**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	_____	

**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: _____

**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

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**(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 completed application form together with payment, before the closing date, to

*Division of Graduate Medical Studies, Yong Loo Lin School of Medicine, MD5 Level 3, NUS,  
12 Medical Drive, Singapore 117598*

*Attn: Eunice Chung/ Aw Yu Chen*

*Tel : (65) 6516 3311/ 7957/ 3300, Fax : (65) 6773 1462*

**FOR OFFICIAL USE ONLY**

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|----|----------------------|---|----------|
| 1. | FEE PAID             | : | SS _____ |
| 2. | CHEQUE/DRAFT NO.     | : | _____    |
| 3. | ACKNOWLEDGEMENT DATE | : | _____    |
| 4. | OFFICIAL RECEIPT NO: | : | _____    |
| 5. | CHECKED BY           | : | _____    |