

MEMBERSHIP APPLICATION FORM

Special Care Dentistry Association of Singapore

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Email: SpecialCareDentistrySingapore@gmail.com



SPECIAL CARE
DENTISTRY ASSOCIATION
SINGAPORE

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Official use only

Name of Applicant:		
Title*: Prof/Dr/Mr/Mrs/Mdm/Ms	Race:	Gender*: Male/Female/Others
Nationality/Citizenship:		Date of birth :
NRIC/FIN/Passport No.:		
Home address:		Tel: (HP)
Postal code:		(Home)
Email:		(Office)
Professional qualifications (include year & university):		SDC Registration No:
Profession*: Dentist/Oral health therapist/Allied dental staffs/Others		Specialty:
Others please specify:		
Institution, clinic or workplace:		Department/Designation:
Work address (including company name):		Preferred mailing address: *Office / Home

MEMBERSHIP APPLICATION FORM

MEMBERSHIP TYPE (please tick one only): <input type="checkbox"/> Ordinary membership (Dentist) <input type="checkbox"/> Ordinary membership (OHT/DT/HT) <input type="checkbox"/> Associate membership <input type="checkbox"/> Student membership [Kindly attach softcopy or hardcopy of student card]	Date of Application:
My application is a: <ul style="list-style-type: none">• New application (Entrance fee is required)• Renewal application (Entrance fee is NOT required)	Total fees payable (S\$):

*delete accordingly

PAYMENT

- Please make cheque/bank draft payable to "**Special Care Dentistry Association of Singapore**". Kindly send to the address above. (Cheque No. _____)
- Or via Internet Banking: Malayan Banking BHD (Transaction No. _____)
Account No. : 04121078235 Bank Code: 7302 Branch Code: 012

I agree to the nomination and accept the terms and conditions stipulated in the SCDAS constitution.

Applicant's Signature

Date:

FOR OFFICIAL USE ONLY:

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Approved by:

Date: