

## REQUEST FOR ATTACHMENT TO SINGHEALTH POLYCLINICS APPLICATION FORM

**Name of Trainee** : \_\_\_\_\_

**NRIC/ Passport No** : \_\_\_\_\_

**Mailing Address** : \_\_\_\_\_

**Email Address/ Contact No** : \_\_\_\_\_

**Category** : Medical Student/ FM Trainee/ Doctor/ Others \*  
**If others, please specify** : \_\_\_\_\_

**Name of current institution** : \_\_\_\_\_

**Period of attachment** : \_\_\_\_\_  
*(A fee of S\$50.00 per week would apply)*

**Objective(s) of attachment** : \_\_\_\_\_

**Is this attachment/ posting part of a formal training program?** **Yes/ No \***  
**If yes, please specify** : \_\_\_\_\_

**Please list/ attach any specific requirements for the attachment/ posting.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Is SingHealth Polyclinics required to submit specific document(s) relating to the organization before the attachment/ posting?** **Yes/ No \***  
**If yes, please specify** : \_\_\_\_\_

**Is SingHealth Polyclinics required to submit any report(s)/ assessment(s) after the attachment/ posting?** **Yes/ No \***  
**If yes, please specify** : \_\_\_\_\_

**Other comments** : \_\_\_\_\_

**Signature of Trainee / Date**

*\* To delete where applicable*

**For Official Use**

*Polyclinic attached to:* \_\_\_\_\_

*Other remarks:* \_\_\_\_\_