**Traditional Chinese Medicine Development Grant**

**Application Form for Individuals**

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| **1. Personal Particulars** |
| **Name** |  |
| **NRIC No.** |  |
| **Contact No.** | (HP) | (O) | (H) |
| **Mailing Address** |  |
| **Profession** |  TCMP TCM Registration No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CMM Dispensers/Clinic AssistantsName and Address of TCM Clinic (for Clinic Assistants only)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **2. Details of CTE courses attended (please attach copy of CPE history report from TCMP Board PRS system or certificate of attendance AND receipts as proof of attendance)** |
| **Date** | **Course Title** | **Organiser** | **Duration (hours)** | **Fees paid (S$)** |
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|  **Total**  |  |
| **Amount Claimable (Total X 0.8)** |  |

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| **3. Declaration** |
| I certify the information given above and the additional attachments, are to the best of my knowledge and belief, accurate and complete. I have not submitted the above claims to any other government agency (ies) for duplicate reimbursement. I understand that MOH reserves the right to reject my/our application and the reason(s) for rejection need not be disclosed. I understand that the decision made by MOH is final. |
| **Name** |  |
| **Signature and Date** |  |