

MEDICAL NEED FORM FOR SMF MOTORISED DEVICE APPLICATION

(Only for first time SMF motorised device applicants who are exempted from AMS)

Important Notes:

- If you are not exempted from AMS, please use the Certificate of Medical Need instead (also known as AMS Certification). The Certificate of Medical Need can be obtained from any of the GPs listed on LTA's website (<https://www.go.gov.sg/ams-gp-list>). Alternatively, you may print a copy of the Certificate of Medical Need (<https://file.go.gov.sg/cmnmform.pdf>) and bring it to the clinic.
- Any amendment(s) made must be signed by a Doctor and affix with the official stamp of the organisation / clinic / hospital, failing which, the form will be deemed incomplete and may be rejected.

TO BE COMPLETED BY A DOCTOR REGISTERED WITH THE SINGAPORE MEDICAL COUNCIL

DOCTOR'S CERTIFICATION - FOR NEED OF A MOTORISED DEVICE

Name of Person Needing Assessment: _____

NRIC of Person Needing Assessment: _____

Doctor's Assessment

1. Does the Applicant have a need for a motorised device for at least 6 months due to medical condition?

☐ Yes (Please proceed to Q2)

☐ No

2. Does the person needing assessment have any condition that will affect the operation of a motorised device?

☐ Yes (Please provide details in Q3)

☐ No

3. Any additional information relating to the person's application for a motorised device.

Doctor's Declaration and Signature

Please tick one only:

☐ The Person Needing Assessment is **not related to me**.

☐ The Person Needing Assessment is **related to me** or otherwise known to me outside my capacity as a registered healthcare professional. I declare that the Person Needing Assessment is my family member or relative / friend / employer / employee / others*(please elaborate: _____).

**Please delete accordingly.*

Declaration

I have assessed the Person Needing Assessment and confirm that the information in this form is true and correct to the best of my knowledge.

Name Stamp, Registration No. & Signature of Doctor	Stamp of Organisation / Clinic / Hospital	Date	Tel No.