



ACADEMY OF MEDICINE, SINGAPORE

NOMINATION FORM
MASTER-ELECT

One candidate per form. Please print or type.

CANDIDATE (MUST BE AN ELECTED COUNCIL MEMBER WITH <u>NO ARREARS AS AT 2 JULY 2015</u>)	
Name of Candidate:	MCR No:
	Mobile No:
Mailing Address:	Email Address:
Signature (indicating consent):	
PROPOSER (MUST BE A CURRENT PAID MEMBER WITH <u>NO ARREARS AS AT 2 JULY 2015</u>)	
Name of Proposer:	MCR No:
	Mobile No:
Email Address:	Signature:
SECONDER (MUST BE A CURRENT PAID MEMBER WITH <u>NO ARREARS AS AT 2 JULY 2015</u>)	
Name of Seconder:	MCR No:
	Mobile No:
Email Address:	Signature:

**Please return the completed form to the Academy of Medicine, Singapore by
Thursday, 2 July 2015, 1700 hours.**

Mail to: Master, Academy of Medicine, Singapore, 81 Kim Keat Road, NKF Centre, #11-00, Singapore 328836 or
via Fax: 6593 7880 or via email to: main@ams.edu.sg

FORM MUST BE COMPLETED TO BE CONSIDERED.

For Official Use

Date and Time Received: _____ Received by: _____