

Manual Submission of Importer and/or Wholesaler's Licence for Oral Dental Gums New/Amend/Renew/Cancel Applications

**Please be informed that the application of Importer and/or Wholesaler's Licence for Oral Dental Gums is to be submitted offline with effect on 1st November 2016.

Note to Applicant:

Amend/Renew (Applicable for payment via non-GIRO only)/New Application

a. Please download the form at PRISM e-services.

b. The form should be completed in English.

c. Please ensure that all mandatory fields (Fields marked with an asterisk*) are completed, including the declaration section. **Incomplete forms will not be processed and will be rejected**.

d. Please send the completed form and related attachments to: Email: <u>HSA Cosmetics Control@hsa.gov.sg</u> , Fax: (65) 6478 9754 or Address: 11 Biopolis Way #11-01 Helios Singapore 138667

e. You will be contacted for payment when the application is being processed.

Cancel Application

f. Please write in to <u>HSA_Cosmetics_Control@hsa.gov.sg</u> if you wish to submit a cancellation application.

FOR OFFICIAL USE

Date received:

Application No:

Cheque/Credit Card/GIRO No:

Cheque/Credit Card/GIRO Amount:

HEALTH SCIENCES AUTHORITY

APPLICATION FOR A WHOLESALER'S LICENCE FOR ORAL DENTAL GUM

☑ Tick where applicable

Fields marked with an asterisk * are mandatory.

[1] Company Particulars

1.1 Name*:

1.2 Company Address

1.2.1 Address Type*: Local / Overseas												
1.2.2 Postal Code*:												
1.2.3 Block/No*: 1.2.4 Level – Unit*:												
1.2.5 Street Name:												
1.2.6 Building Name:												
1.2.7 Country*:												
1.3 Tel:* 1.4 Fax:												

1.5 Is Billing Address the same as the Company Address*? Yes/No

1.6 Billing Address

1.6.1 Address Type*: Local													
1.6.2 Postal Code*:													
1.6.3 Block/No*: 1.6.4 Level-Unit*:													
1.6.5 Street Name:													
1.6.6 Building Name:													
1.6.7 Country*:													
1.7 Tel*: 1.8 Fax:													
1.9 Unique Entity No (UEN):													
[2] Applicant Particulars													
2.1 Name*:													
2.2 NRIC/FIN*:													
2.3 Designation*:													

2.4 Contact Details

2.4.1	Те	*:													2	.4.	2 F	ax	:					
2.4.3	2.4.3 Handphone*:																							
2.4.4	2.4.4 Email:																							
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2.5 Preferences

2.5.1 Preferred Contact Mode*: Email/Fax/SMS

Note: Please ensure that the relevant contact details above are entered for your preferred contact mode. Please note that this preferred contact mode is the mode which you will receive the final notification of this application. During the course of this application, you will receive our input requests (i.e. queries), if any, via email if you have indicated your email address above, regardless of your selected preferred contact mode

[3] Store Particulars

3.1 Name*:

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3.2.1 Address Type*: Local

3.2.2 Postal Code*:												
3.2.3 Block/No*: 3.2.4 Level – Unit*:												
3.2.5 Street Name:												
3.2.6 Building Name:												
3.2.7 Country*:												
3.3 Tel*: 3.4 Fax:												

[4] Product(s)

4.1 List of oral dental gums to be imported*:

S/No	Brand Name

[5] Declaration*

- 1. I have been authorised by the company to make this application.
- 2. I undertake to notify the Authority within 7 days of any change in the particulars submitted in this application and of any adverse side effect reported on the oral dental gums imported by the company.
- 3. I declare that the particulars given in this application are true and that all data, reports and information of relevance in relation to the application have been supplied and that the documents enclosed are authentic or true copies.

[Signature of Applicant]

[Date]

[Name of Applicant]

Payment Advice

Sn Description

Amount (SGD)

1 App n Ren Wholesale Lic Oral Dental Gum

The total payment for your application is _____.

Existi	ing GIRO Client (Your bank account will b	be deducted accordingly,)
For c	lients not on GIRO payment (please tick	one of the below options)
	CREDIT CARD (please tick Visa or	r Mastercard)	
	• Visa • Mastero	card	
Name of Cardholder:		Card Expiry Date:	
Card No:		Charge Amount:	SGD
	CHEQUE		
Name of Bank:	Cheque No:	Amount:	SGD
 Singapore cheques 	should be made payable to "Health Scie	nces Authority" and in Sl	NGAPORE Dollars

Please make payment using one of the following modes (please tick where appropriate):

(SGD).2) Please indicate company name, contact number and application details at the back of the cheque.