# SELF SWAB GRANT APPLICATION FORM

Before filling in this Application Form, please make sure that you have read through the Grant guidelines, including the terms and conditions for Self Swab Grant herein attached.

Please complete Sections **A** to **C** and submit the following documents to us at [selfswabgrant@hpb.gov.sg:](mailto:selfswabgrant@hpb.gov.sg)

1. Application Form
2. Copy of Company ACRA
3. Copy of Licensing Approval from MOH
4. Copy of Accreditation of partnering HCI licensed under PHMCA

# Application Form

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| Section A | Applicant Details |
| Section B | Grant Components |
| Section C | Declaration |

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| **SECTION A – APPLICANT DETAILS** | | | | |
| **Company Name** (registered name  under ACRA) |  | | | |
| **Total Pax to be Swabbed**  (please provide breakdowns of dorm/non-dorm/others,  if applicable) |  | | | |
| Dorm | | Non-Dorm | RRT cycle (7/14 days): |
| **Location of Swab Sites** |  | | | |
| **Operating Days/Hours at each swab site per RRT**  (For swab/ re-swab) |  | | | |
| **Number of Swab Stations at each swab Site** (estimated) |  | | | |
| **Partnering Healthcare Provider** |  | | | |
| **Partnering Test Lab (PCR)** | | **Pooled Testing Ratio** | | |
| **Additional Information, if any** |  | | | |

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| **SECTION B – GRANT COMPONENTS** | | | |
| **Category** | **Description** | | |
| **Funding** | $12 nett for each Swab or Re-swab  $90 nett for each Lab test | | |
| **Category** | **Description** | **Yes** | **No** |
| **Required Confirmations**  (please tick where applicable) | Please confirm that you understood the requirement to use the **Swab Registration System (SRS)** for the Self Swab. |  |  |
|  | Please confirm that you understood the requirement that the Company is to provide the list of essential items required for the Self Swab.   1. Personal Protection Equipment (PPE) 2. Consumables (for donning area, doffing area, registration station, swab station) 3. IT equipment (Laptop, Wifi dongle, scanner, label printer, label rolls) |  |  |

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| **OFFICIAL USE (SECTION B – GRANT COMPONENTS)** |
| **HPB's Assessment:** |
| |  | | --- | |  | |  | |  |   Overall Assessment: -  Yes, all submissions are complete.  Total Number of Pax eligible :  (as stated in Section A)  No, submissions are not complete. Please refer to remarks below.  Remarks: |
| **SECTION C – DECLARATION** |
| \*I/We, the undersigned, hereby confirm that:   1. All the information contained herein and submitted with this Application Form is true and accurate. \*I/We undertake to promptly inform and update the Health Promotion Board ("**HPB**") of any changes to the information contained herein and submitted with this Application Form. 2. \*I/We have read and understood the requirements of the Self Swab Grant Guidelines, including the terms and conditions for Self Swab Grant before submitting this Application Form, and hereby agree to comply with such guidelines. 3. \*I/We understand that HPB reserves the unconditional right to:    1. require the submission of further information or material to assess this Application Form;    2. accept, reject or require amendments to this Application Form;    3. conduct checks to verify any information submitted in this Application Form;    4. take action against any inaccurate, untrue, false or misleading information that may be supplied in this Application Form or in any submission to HPB;    5. change or vary any part of this Application Form (including any supporting documents required hereunder); and    6. amend, vary, restrict, suspend or terminate any aspect of the Self Swab Grant and/or amend or vary any of the Self Swab Grant Guidelines. |
| [● NAME OF COMPANY] *(please include company stamp)*  Name of Authorised Signatory: [●] Designation (CEO/MD equivalent): [●] Date: |

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| **OFFICIAL USE ( SECTION A-B)** | | |
| **HPB’s Assessment:** | | |
| Name of HPB assessing officer: AM/M/SM  Date: | | |
| **Approval:** | | |
| SM/AD | DD | D |
| Name/ Date | Name/ Date | Name/ Date |
| Conflict of interest: Yes/No\* | Conflict of interest: Yes/No\* | Conflict of interest: Yes/No\* |