



**Clinical Report Authorisation Form**

For Withdrawal of CPF Under Section 15 of the Central Provident Fund Act (Chapter 36)

This form may take you 3 minutes to complete

**Warning:** It is an offence to make any false statement or to produce or furnish any document which is false for any purpose connected with this Act.  
**Note:** Member must sign against any amendment made. Use of correction fluid/tape is not allowed.

**To: Doctor – In – Charge**

**I hereby authorise you to furnish a detailed medical report to the Central Provident Fund Board on:**

**Name of Patient** - \_\_\_\_\_

**NRIC** - \_\_\_\_\_

**Illness(es)** - \_\_\_\_\_

**Doctor** - \_\_\_\_\_

**Hospital/Clinic** - \_\_\_\_\_

**Date** - \_\_\_\_\_

**I agree that a photocopy of this authorisation shall be as effective and valid as the original. The medical report is required to support the application for withdrawal of CPF savings on medical grounds under Section 15 of the Central Provident Fund Act.**

\_\_\_\_\_  
 Signature/Right Thumb Print of patient\*

\_\_\_\_\_  
 Contact No.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Email Address

**\*If the patient is below age 21 or lacks mental capacity, this authorisation form must be completed by the next-of-kin.**

\_\_\_\_\_  
 Signature/Right Thumb Print of next-of-kin

\_\_\_\_\_  
 Signature/Right Thumb Print of Witness\*\*

Name: \_\_\_\_\_

Name: \_\_\_\_\_

NRIC: \_\_\_\_\_

NRIC: \_\_\_\_\_

Relationship with patient: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Contact No.: \_\_\_\_\_

Contact No.: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\*\* The witness must be of age 21 and above and is of sound mind.