

## Application for Claim of Handicapped-Related Tax Reliefs

This form must be completed if you are claiming the handicapped-related tax relief(s) for the first time. The form is to be retained by you and you may be requested to submit it for verification of claim(s).

This form may take you 5 minutes to fill in. Please have your dependant's and your personal particulars with you.

Please note that Section 3 should be completed by doctor(s) registered with the Singapore Medical Council. For doctor assessment(s), please bring along your/ the dependant's medical reports and/ or medications.

Please note that you may incur administrative/ medical assessment fees for this form to be completed by the registered doctor.

### Section 1 – Your Personal Particulars

Full name: \*Mr/ Mrs/ Miss/ Ms \_\_\_\_\_ \*NRIC/ FIN/ Passport No: \_\_\_\_\_

Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (HP) \_\_\_\_\_ (O) \_\_\_\_\_

### Section 2 – Type of Handicapped-related Relief claiming for

(i) Please tick the type of handicapped-related relief you are claiming for:

Self       Spouse       Child       Parent       Brother/ Sister

(ii) Please provide details of your dependant (if applicable):

Full name: \*Mr/ Mrs/ Miss/ Ms \_\_\_\_\_ \*NRIC/ FIN/ Passport No: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \*Male/ Female Relationship to claimant: \_\_\_\_\_

### Section 3 – Comments by Doctor (to be completed by doctor who is providing information on the case)

**Please complete Part (A) if the individual suffers from physical handicap or Part (B) if the individual suffers from mental disability/disorder. Part (C) should be completed for ALL cases.**

Part (A) – For physical handicap cases:

(i) The individual stated in Section 2 above suffers from \_\_\_\_\_  
(Please state type of physical handicap, e.g. blindness or deafness)

(ii) \*He/ She needs assistance in the following Activities of Daily Living needs:

Activities of Daily Living	Please Select	Doctor's Remarks / Comments
Washing or Bathing [Ability to bathe or shower (including getting into and out of the bath or shower) or wash by other means]	*Yes/ No	
Dressing [Ability to put on, take off, secure and unfasten all garments (upper and lower) and any braces, artificial limbs or other surgical appliances]	*Yes/ No	
Feeding [Ability to feed oneself after food has been prepared and made available]	*Yes/ No	
Toileting [Ability to use the toilet or manage bowel and bladder function through the use of protective undergarments or appropriate surgical appliances]	*Yes/ No	

\* Delete where applicable



Activities of Daily Living	Please Select	Doctor's Remarks / Comments
Transferring [Ability to move from (a lying position on the) bed to an upright chair or wheelchair, and vice versa]	*Yes/ No	
Mobility [Ability to move indoors from room to room on level surfaces]	*Yes/ No	

**Part (B) – For mental handicap cases:**

- (i) The individual stated in Section 2 above suffers from \_\_\_\_\_  
(Please state type of Mental Disability/Disorder, e.g. Schizophrenia, Dementia, Mental Retardation, etc)
- (ii) \*He/ She is impaired in the following areas:

Activities	Please Select	Doctor's Remarks / Comments
Self Care and Activities of Daily Living [Ability to care for self and independently manage activities of daily living ( i.e. washing/bathing, dressing, feeding, toileting, transferring, mobility)]	*Yes/ No	
Compliance to Psychiatric Treatment [Ability to take medications and comply with prescribed psychiatric treatments]	*Yes/ No	
Education & Work [Ability to integrate into the normal stream of education or to sustain gainful employment]	*Yes/ No	

**Part (C) – To be completed for all cases**

- (i) The \*mental/ physical handicap has commenced since \_\_\_\_\_ (yyyy).
- (ii) The \*mental/ physical handicap \*is/ is not permanent.
- (iii) The status of \*mental/ physical handicap is expected to change within \_\_\_\_\_ years.

Additional comments (if any):

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\_\_\_\_\_  
Name of Doctor

\_\_\_\_\_  
Official stamp of clinic/ hospital

\_\_\_\_\_  
Signature of Doctor

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

\_\_\_\_\_  
Date

\* Delete where applicable