Adventist 港 Health 安
Hong Kong Adventist Hospital · Tsuen Wan
香港港安醫院·荃灣

Personal Information Collection Statement

Purpose of Collection

The information provided by you will be used to process your admission privilege application. All information provided will be kept in strict confidence.

Time Period of Retention

Information of unsuccessful or incomplete applicants will be destroyed after 6 months.

Classes of Transferees

Medical Affairs Office may give some of the information to other parties authorized to receive it (such as direct marketing of health services and promotion purpose). We will obtain your consent before using your Personal Data for any other purposes.

Access to Personal Data

You have a right to request access to and correction of your personal data as provided for in sections 18 and 22 and Principle 6 of Schedule 1 of the Personal Data (Privacy) Ordinance. Your right of access includes the right to obtain a copy of your personal data provided in this application form.

Request for personal data access and correction relating to your admission privilege application should be addressed to Medical Affairs Office of Hong Kong Adventist Hospital – Tsuen Wan.

Hong Kong Adventist Hospital – Tsuen Wan
199 Tsuen King Circuit, Tsuen Wan, Hong Kong
Tel. No.: 2275 6711
Fax No.: 2275 6473

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PLEASE ATTACH RECENT PHOTO HERE

INSTRUCTIONS
1. *This form should be typed if possible.*
2. *Use additional sheets (or the back page) for additional space.*
3. *Attach photocopies of all documents.*

IDENTIFYING INFORMATION

Name In English		Chinese Name
Date of Birth (dd/mm/yyyy)	Place of Birth	Citizenship
Sex	HKID Number	Marital Status
Corresponding Address		
Home Address		
Office Telephone	Office Fax	Email Address
Pager	Mobile Phone	Home Telephone

MEDICAL/ DENTAL INFORMATION

PreMedical / PreDental School / College / University	Degree	Date of Graduation
Medical / Dental School	Degree	Date of Graduation

Specialty Training:

Specialist Qualification	Since	
Hospital	From	To
Hospital	From	To

Chronological list of medical / dental activities since internship or residency.

PREVIOUS PRACTICE(S)

All previous practice(s) in chronological order: Please give full chronological information including last date of practice.

Address	From	To
Address	From	To

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Name	Membership Status	Year
Name	Membership Status	Year

FELLOWSHIP ACADEMY OF MEDICINE

Name	Membership Status	Year
Name	Membership Status	Year

LICENSE TO PRACTISE

Hong Kong Medical Council: ( )

Hong Kong	License Number (provide photo copy of current license)	Date Issued
Others	License Number	Date Issued

HEALTH STATUS

If any of the following questions are answered in the affirmative, please provide full explanation on a separate sheet.

Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects or likely to affect your ability to perform professional or medical staff duties appropriately? ☐ Yes ☐ No

Are you currently under care for a continuing health problem? ☐ Yes ☐ No

Have you at any time during the last five years been hospitalized or received any other type of institutional care for a health problem? If "Yes", please specify below. ☐ Yes ☐ No

OTHER INFORMATION

Please indicate your Insurance Carrier details:

Insurance Carrier _____ Expiration Date _____

If the answer to any of the following questions is "Yes", please give Full Details on separate sheet of paper.

A. *Has your license to practice medicine/dentistry in any jurisdiction ever been limited, suspended or revoked?* ☐ Yes ☐ No

B. *Have you ever been refused membership on a hospital medical/dental staff?* ☐ Yes ☐ No

C. *Has your request for any specific clinical privilege ever been denied or granted with stated limitations?* ☐ Yes ☐ No

D. *Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed?* ☐ Yes ☐ No

E. *Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical/dental organization?* ☐ Yes ☐ No

F. *Have you been convicted of any indictable criminal offense?* ☐ Yes ☐ No

G. *Have you been involved with any medical or dental litigation in which an award has been made against you?* ☐ Yes ☐ No

PROFESSIONAL REFERENCES

Include **TWO** physicians familiar with your clinical practice with at least one referee must be a physician who is practicing the **same** specialty as you,

Doctor	Contact Address / Fax No. / Email Address
Doctor	Contact Address / Fax No. / Email Address

** Note: If applying for special procedure privileges, please indicate one doctor above for relevant reference, or an additional reference per privilege requested.*

PRIVILEGES DESIRED

- ☐ Admission of patients
- ☐ Anaesthesiology
- ☐ Cardiac Catheterisation & Intervention
- ☐ Conscious Sedation **(Please provide supporting cert/doc)**
- ☐ Endoscopy: Bronchoscopy*
- ☐ Endoscopy: Gastroscopy*
- ☐ Endoscopy: Colonoscopy*
- ☐ Endoscopy: Cystoscopy*
- ☐ Endoscopy: ERCP*
- ☐ Lithotripsy*
- ☐ Neonatology
- ☐ Paediatrics
- ☐ Maternity
- ☐ OT: Surgical procedures relating to specialty
- ☐ OT: Minimally invasive surgical procedures related to specialty
- ☐ OT: Bariatric Surgery
- ☐ OT: Spinal Surgery
- ☐ OT: Specified procedures

  _____
- ☐ Radiotherapy
- ☐ Others (please specified):

  _____

AGREEMENT STATEMENT

I have read the Code of Practice of the Private Hospitals Association and I agree to abide by it.

I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical/dental staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical/dental staff of this hospital, I acknowledge that I have received and read the by-laws, rules and regulations of the medical staff of this hospital. I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted. I understand that by not following the rules and regulations, my privileges may be suspended.

I understand and agree that I, as an applicant for medical/dental staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

APPLICANT'S SIGNATURE

NOTE:
A doctor's specimen signature and initial are used by Hospital staff for verification. Please sign with black ball pen.

Signature of Applicant

Signature: _____

Initial: _____

Name: _____

***Date*_____**

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APPLICATION FOR SPECIAL PROCEDURE PRIVILEGE

Name of applicant: _____ Specialty: _____

I would like to apply for the privilege(s) to perform the following procedure(s) in your Hospital:

Name of the procedure	No. Performed Within Past Five Years
1. Endoscopy: Bronchoscopy	_____
2. Endoscopy: Gastroscopy	_____
3. Endoscopy: Colonoscopy	_____
4. Endoscopy: Cystoscopy	_____
5. Endoscopy: ERCP	_____
6. Lithotripsy	_____
7. Others:_____	_____

(※Please provide supporting documents, e.g. log book etc.)

Name, address & contact number of referees (in the same specialty):

1. _____

_____

_____

2. _____

_____

_____

Signature of Applicant: _____ Date: _____

Privilege Status (For OFFICE Use Only):

☐ Accept ☐ Decline

☐ Selective privilege:

_____

Approved by: _____ Date: _____

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Autopay Form

I. Basic Information

Doctor's Name : _____ [Full Name]

HKID Card No. / Passport No. : _____ Sex: _____

Date of Birth : _____ Marital Status: _____

II. Bank Account and Contact Information

[Please tick the appropriate box.]

☐ New application

☐ Change bank account information

- ☐ Dr. Code _____
- ☐ All my Dr. Codes

☐ Apply for extra doctor code

Effective date: _____

☐ **I would like to set up the following bank account as my default autopay account.**
ALL doctor fee will be sent to the default account if no doctor code is written in billing sheet.

Bank Account No. : _____ - _____ - _____

Bank Code ***Branch Code*** ***Account Number***

Account Name : _____

Business Registration No. : _____
(*if applicable)

Copy of Business Registration certificate <u>MUST</u> be provided for company bank account

Contact Telephone Number: _____ Fax: _____

Correspondence Email : _____

Correspondence Address : _____

_____

Doctor's Signature: _____ Date: _____

Please return the form to Medical Affairs Office by medicalaffairsoffice@twah.org.hk (Email) / **2275 6473** (Fax) or mail to Hong Kong Adventist Hospital - Tsuen Wan, 199 Tsuen King Circuit, Tsuen Wan, N.T. Thank you!

Doctor's Code: _____

Check List for Doctors Application of Admission Right

Doctor's Name: _____ Specialty: _____

- ☐ Completion of application form with recent photo
- ☐ Business Card
- ☐ Application form for special procedure with supporting documents (if applicable)
- ☐ Two Reference Letters (at least one reference in selected field of specialty)
- ☐ CV
- ☐ License of Registration
- ☐ Certificate of Specialist Registration (if applicable)
- ☐ Certificates of relevant qualifications
- ☐ Annual Practicing Certificate

  MCHK No: _____

  Expiry Date: _____
- ☐ Medical Protection Society Membership Certificate

  Hospital Rates: _____

  Expiry Date: _____
- ☐ Irradiating Apparatus Licence (For Cardiologists, Urology & Orthopaedics & Traumatology)
- ☐ Autopay Form

[For Internal Use] Temporary Privilege Approved:

By: _____ (Asst. COMS) on _____

By: _____ (COMS) on _____

Remarks: _____

_____