

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

PREVIOUS PRACTICE(S)

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

Address	From	To
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Address	From	To
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MEMBERSHIP IN PROFESSIONAL SOCIETIES

Name	Membership Status	Year
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Name	Membership Status	Year
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FELLOWSHIP ACADEMY OF MEDICINE

Name	Membership Status	Year
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Name	Membership Status	Year
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LICENSE TO PRACTISE

Hong Kong Medical Council: ()		
Hong Kong	License Number (provide photo copy of current license)	Date Issued

Others	License Number	Date Issued
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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
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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 found guilty of misconduct in a professional respect in a disciplinary inquiry of the Medical / Dental Council of Hong Kong?* 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

<input type="checkbox"/> Admission of patients	<input type="checkbox"/> Maternity
<input type="checkbox"/> Anaesthesiology	<input type="checkbox"/> OT: Surgical procedures relating to specialty
<input type="checkbox"/> Cardiac Catheterisation & Intervention	<input type="checkbox"/> OT: Minimally invasive surgical procedures related to specialty
<input type="checkbox"/> Conscious Sedation (Please provide supporting cert./doc.)	<input type="checkbox"/> OT: Bariatric Surgery
<input type="checkbox"/> Endoscopy: Bronchoscopy*	<input type="checkbox"/> OT: Spinal Surgery
<input type="checkbox"/> Endoscopy: Gastrosocopy*	<input type="checkbox"/> OT: Robotic Surgery (Hugo RAS)
<input type="checkbox"/> Endoscopy: Colonoscopy*	<input type="checkbox"/> OT: Robotic Surgery (da Vinci Xi)
<input type="checkbox"/> Endoscopy: Cystoscopy*	<input type="checkbox"/> OT: Specified procedures
<input type="checkbox"/> Endoscopy: ERCP*	_____
<input type="checkbox"/> Lithotripsy*	<input type="checkbox"/> Radiotherapy
<input type="checkbox"/> Neonatology	<input type="checkbox"/> Others (please specified):
<input type="checkbox"/> Paediatrics	_____

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 _____

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 MUST be provided for company bank account***

Contact Telephone Number: _____ Fax: _____

Correspondence Email : _____

Correspondence Address : _____

Doctor's Signature: _____ Date: _____

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 Practising Certificate

MCHK No: _____

Expiry Date: _____

- Medical Protection Society Membership Certificate

Hospital Rates: _____

Expiry Date: _____

- Irradiating Apparatus Licence (for Cardiology, Dental, General Surgery with ERCP, Neurosurgery, Orthopaedics & Traumatology, Radiology, Urology, and Vascular Surgery)
- Autopay Form with bank statement, and Business Registration (if applicable)
- Car Park Registration Form (if applicable)

[For Internal Use] Temporary Privilege Approved:

By: _____ (Asst. COMS) on _____

By: _____ (COMS) on _____

Remarks: _____
