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| **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. |
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| 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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| **Hong Kong Adventist Hospital – Tsuen Wan**  199 Tsuen King Circuit, Tsuen Wan, Hong Kong  Tel. No.: 2275 6711 Fax No.: 2275 6473 | | | | | | | | | | | | | *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.* | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | |
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| **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 |
|  |  | | | | | | | | | | | | | | | | |
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| **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.** | | | | | | | | | | | | | | | | |
|  |  |  | | | | | | | | | | | | | |  |  |
|  | 1. *Has your license to practice medicine/dentistry in any jurisdiction ever been limited, suspended or revoked?* | | | | | | | | | | | | | | | Yes | No |
|  | 1. *Have you ever been refused membership on a hospital medical/dental staff?* | | | | | | | | | | | | | | | Yes | No |
|  |  | | | | | | | | | | | | | | |  |  |
|  | 1. *Has your request for any specific clinical privilege ever been denied or granted with stated limitations?* | | | | | | | | | | | | | | | Yes | No |
|  |  | | | | | | | | | | | | | | |  |  |
|  | 1. *Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed?* | | | | | | | | | | | | | | | Yes | No |
|  |  | | | | | | | | | | | | | | |  |  |
|  | 1. *Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical/dental organization?* | | | | | | | | | | | | | | | Yes | No |
|  | 1. *Have you been convicted of any indictable criminal offense?* | | | | | | | | | | | | | | | Yes | No |
|  |  | | | | | | | | | | | | | | |  |  |
|  | 1. *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 |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Endoscopy: Gastroscopy |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Endoscopy: Colonoscopy |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Endoscopy: Cystoscopy |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Endoscopy: ERCP |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Lithotripsy |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Privilege Status (For OFFICE Use Only):**

* Accept □ Decline
* Selective privilege: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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. Code.

□ Apply for extra doctor code

Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **I would like to set up the following bank account as my default autopay account.**

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return the form to Medical Affairs Office by [**Carmen.ng@twah.org.hk**](mailto:Carmen.ng@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
* Certificate 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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