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

Hong Kong Adventist Hospital - Tsuen Wan

MEDICAL/DENTAL STAFF PRIVILEGE RENEWAL

Tel: 2275 6711
Fax: 2275 6473
Email: medicalaffairsoffice@twah.org.hk
Address: 199 Tsuen King Circuit, Tsuen Wan

Revised Jul 2025

For Office Use Only

Physician # _____

Malpractice Insurance Expiry Date (effective until): _____

Medical Indemnity: _____

Comments: _____

Approval Signature: _____ *(Chief of Medical Staff)*

PLEASE ATTACH RECENT PHOTO HERE

INSTRUCTIONS

This form is for the next three years and is intended to up-date your file so that it will reflect your current status.

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 Full (both in English & in Chinese, if you have a Chinese name) *Physician Code #*

HKID Card No. / Passport No. *Date of Birth*

Corresponding Address

Home Address

Office Telephone *Office Fax* *E-mail Address*

Pager *Mobile Phone* *Home Telephone*

PRIVILEGES

Specialty: _____

Any Changes Requested ☐ Yes ☐ No If YES, attach documentation of training or experience

HEALTH STATUS

Personal Health Status (Including Alcohol & Drug Dependence)

Please declare whether you are having any medical and/or mental condition that may affect in any way your practice of medicine in the Hospital (use separate sheet if necessary).

❑ *Yes:* _____

_____

❑ *Nothing to declare*

(If you have anything to declare to the Hospital Administration about your medical/mental condition, you can consider keeping it confidential and put it into an sealed envelope.)*

OTHER INFORMATION

A. *Are you still on the specialist list of the Medical Council of Hong Kong / the Dental Council of Hong Kong?* ..... ❑ *Yes* ❑ *No*

B. *Are you covered by malpractice insurance? (Please provide a copy)* ..... ❑ *Yes* ❑ *No*

C. *Has your licence to practice medicine/dentistry in any jurisdiction ever been limited, suspended or revoked?* ..... ❑ *Yes* ❑ *No*

D. *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*

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

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

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

H. *Have you been convicted of any indictable criminal offense?* ..... ❑ *Yes* ❑ *No*

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

AGREEMENT STATEMENT

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 reappointment 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, and code of practice of the Private Hospitals Association (PHA). I further agree to abide by such hospital and staff rules and regulations and code of practice of PHA as may be from time to time enacted. Failure to follow the rules and regulations and code of practice may jeopardize my admitting privileges.

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.

*****Please send copy of annual license to practice in Hong Kong and current valid Malpractice Insurance Certificate with receipt.***

APPLICANT'S SIGNATURE

Signature: _____

Initial: _____

Name: _____

Date: _____

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