

## Hong Kong Adventist Hospital - Tsuen Wan

### MEDICAL/DENTAL STAFF PRIVILEGE RENEWAL

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 Address: 199 Tsuen King Circuit  
 Tsuen Wan

**Aug 2021**  
 Please **PRINT**

**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 any thing 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. Since your last application, have you been convicted by the Medical/Dental Council of Hong Kong? .....  Yes  No
- D. Has your licence to practice medicine/dentistry in any jurisdiction ever been limited, suspended or revoked? .....  Yes  No
- E. Have you ever been refused membership on a hospital medical/dental staff?.....  Yes  No
- F. Has your request for any specific clinical privilege ever been denied or granted with stated limitations? .....  Yes  No
- G. Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed? .....  Yes  No
- H. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical/dental organization?.....  Yes  No
- I. Have you been convicted of any indictable criminal offense? .....  Yes  No
- J. 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 ink.)**