

## Application Form for Admission Right and Clinical Privileges

Please submit the following documents together with the completed application form:

- Recent Photo (passport-sized)
- Application form on Scope of Clinical Practices (if applicable)
- Curriculum Vitae
- A reference letter from one of the medical doctors listed in Part VI
- Proof for Quotable Qualifications
- Licence/Certificate of Registration
- Certificate of Specialist Registration (if applicable)
- Valid Annual Practising Certificate
- Copy of medical indemnity insurance certificate/receipt. The coverage should commensurate with relevant specialty and scope of practices.
- Copy of Hong Kong Identity Card/Passport  
Name Card



### Part I Personal Particulars

<b>English Name</b>			
<b>Chinese Name</b>		<b>Sex</b>	F / M
<b>HKID No.</b>		<b>Date of Birth</b>	(dd/mm/yyyy)
<b>Nationality</b>		<b>Car Plate No.</b>	
<b>Clinic Address</b>			
<b>Clinic Tel. No.</b>		<b>Clinic Fax No.</b>	
<b>Residence Address</b>			
<b>Mobile No.</b>		<b>Fax No.</b>	
<b>E-mail Address</b>			

### Part II Contact Numbers for Clinical Emergency (with priorities)

During usual office hours		Outside office hours	
1		1	
2		2	

### Part III Quotable Qualifications (in chronological order)

Please provide only quotable qualifications and submit documentation proof.

Attained Year	Qualification	Institution	Country Issued

**Part IV Specialty / Primary Care Training** (in chronological order)

From	To	Hospital

**Part V Employment Record** (in chronological order)

From	To	Employer	Position	Department / Unit

**Part VI Professional References**

Name of Referee	Position	Contact No.	Email Address

**Part VII Licence to Practice**

Licence/Certificate Awarded by The Medical Council of Hong Kong	Registration No.	Registration Date (dd/mm/yyyy)
Licence/Certificate of Registration		
Certificate of Specialist Registration (if applicable) (Specialty in: _____ )		
Annual Practising Certificate		Valid until:

**Part VIII Professional Indemnity**

Professional Indemnity Provider and Membership No: _____ / _____
Valid until (dd/mm/yyyy): _____
Category of indemnity: _____

**Part IX Health Status**

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

1. Do you presently have a physical or mental health condition, including alcohol or drug dependence, that may affect your ability to perform professional duties appropriately?  
 No       Yes, please specify: \_\_\_\_\_
  
2. Are you currently under care for a continuous health problem?  
 No       Yes, please specify: \_\_\_\_\_
  
3. Do you have annual checkup? (applicable for applicant aged seventy or above)  
 No       Yes, please specify: \_\_\_\_\_

**Part X Application for Admission Right and Clinical Privileges**

	Number Performed Within Past 2 Years	FOR HOSPITAL USE ONLY	
		Granted	Declined
<input type="checkbox"/> Admission of patients	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anaesthesiology	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cardiac Catheterization & Intervention	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Critical Care / Intensive Care	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Endoscopy: Bronchoscopy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Endoscopy: Gastroscopy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Endoscopy: Colonoscopy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Endoscopy: Cystoscopy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Endoscopy: ERCP		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lithotripsy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neonatology	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neurology	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Paediatrics	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Maternity	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OT: Surgical procedures relating to specialty	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OT: Minimally invasive surgical procedure	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OT: Spinal Surgery	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OT: Specified procedures: _____	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Radiotherapy	N/A	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Others (please specify): _____		<input type="checkbox"/>	<input type="checkbox"/>

**Part XI Declaration**

I hereby declare that:

- i) I have read the Personal Information Collection Statement (For Application of Admission Right & Clinical Privileges) in Appendix 1, and consent that CUHK Medical Centre (CUHKMC) is entitled to use my personal data as stated in the Statement;
- ii) I have not violated any offence of professional misconduct nor convicted by the Medical Council of Hong Kong; and I am not involved in any disciplinary enquiry nor hearing at the material time; and
- iii) All statements on this application and all attached documents are true and correct to the best of my knowledge.

I understand that CUHKMC collects this information and may further solicit additional information so as to be informed of my previous personal and professional record.

I further understand and agree that:

- i) any falsification or omission of facts by me may constitute to the disqualification to this application;
- ii) the granting of the admission right and clinical privileges are at the full discretion of CUHKMC; and
- iii) any professional misconduct or criminal behavior may be considered in future review of my admission right and clinical privileges by CUHKMC.

I consent to allow CUHKMC to audit the clinical outcomes of patients under my care.

I understand that my signature and initials below will be captured in the Hospital Information System for verification of prescription orders and/or treatment for documentation.

Name in BLOCK Letters: \_\_\_\_\_

Signature: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Notes:**

1. Please send the completed application form together with the required documents to Human Resources Department via email to vms@cuhkmc.hk or mail to CUHK Medical Centre, 9 Chak Cheung Street, Shatin, New Territories, Hong Kong.
2. Administrative processing normally takes 4-6 weeks. For enquiry, please contact Human Resources Department via email to vms@cuhkmc.hk
3. Letter of notification will be sent to the Applicant by email, informing result of CUHKMC's decision.
4. Privileges are granted on a 3-year basis and subject to renewal.
5. Applicant is required to inform CUHKMC in writing, whenever there is any change of personal data.
6. Applicant is required to send the annual update of Practising Certificate and Malpractice Insurance Certificate to CUHKMC.

**FOR CUHKMC USE ONLY**

Received on \_\_\_\_\_ (Date)

Interview on \_\_\_\_\_ (Date)

Application to be submitted to MAC on \_\_\_\_\_ (Date)

**Doctor Code:** \_\_\_\_\_

**PERSONAL INFORMATION COLLECTION STATEMENT  
(FOR APPLICATION OF ADMISSION RIGHT & CLINICAL PRIVILEGES)**

**1. Purpose of Collection**

The personal data provided by you will be used by the CUHK Medical Centre (CUHKMC) to process your application for admission right and clinical privileges with CUHKMC and will be subject to audit as CUHKMC deems necessary.

**2. Transfer of Personal Data**

Your personal data held by CUHKMC will be kept strictly confidential, and will only be disclosed to authorised persons within CUHKMC for processing your application and/or may be transferred and disclosed to a third party nominated by CUHKMC and bound by a duty of confidentiality to assist with CUHKMC's review of your application.

**3. Access and Correction of Personal Data**

Under the Personal Data (Privacy) Ordinance, you have the right to request access to and correction of your personal data held by CUHKMC. Such request should be made in writing and addressed to:

Chief Human Resources Officer  
Human Resources Department  
9 Chak Cheung Street  
Shatin, New Territories  
Hong Kong

CUHKMC has the right to charge a reasonable fee for the costs related to your request for data access, as permitted under the Personal Data (Privacy) Ordinance.

**4. Retention of Personal Data**

Unsuccessful or incomplete applications will be kept no more than 6 months from the application date, and will be destroyed thereafter.

If your application is successful, relevant data will be disclosed to authorised persons within CUHKMC and/or captured in CUHKMC's systems to facilitate the execution of your admission right, clinical privileges and administration of related matters.

All information provided will be treated in strict confidence and used for the said purposes only.