UNION HOSPITAL

HMA Department **Application Form for Admission Right & Clinical Privileges**

Instruction Notes:

(i) All applicants must complete this form to apply for admission right and the corresponding clinical privilege application form(s) as listed under section III when appropriate.

(ii) Please provide supporting evidence of related training and experience. You may add supplementary sheet if there is insufficient space.

(iii) Please submit this application form together with corresponding clinical privilege form(s) and supporting documents by post to Human Resources Department, Union Hospital, 18 Fu Kin Street, Tai Wai, NT. Please mark "Application for Admission Right & Clinical Privileges" on the envelope.

(iv) Application processing normally **takes about 12 weeks**. To check status of your application, please contact Human Resources Department at 2608 3158 or email to vms@union.org.

(v) All personal data collected will be treated in strict confidence and be used for application purposes only.

For Hospital Use Only
Date received: _____
App. Ref. No.:_____
Doctor's code:_____

Please complete this form in BLOCK letters. (*) indicates mandatory entry.

I. Personal Particulars

*English Name				RECENT PHOTO
*Chinese Name		*Sex	#M / F	
*Date of Birth (dd/mm/yyyy)		*HKID No. / Passport No.		
*Specialty (Sub-specialty if any)				
*Specialist Registration No.				
*Home Tel. No.		*Pager No. (if any)		*For emergency contact*
*Mobile No. (with SMS and instant messaging)	Can the number be disclosed to patients on business card? ❑ Yes ❑ No			*For communication with UH staff related to patient management. Information will be disclosed in Hospital Intranet, Telephone Directory and Clinical Management Programs*
*E-mail				
*Correspondence Address *(For posting of all documents, bills and reports of the hospital)*				

II. Current Practice

#Private Practice / Institution		since (year)	
Position			
Address			
Office Tel. No.		Fax No.	

For applicant currently working in public institutes, please indicate below whether you are planning to set up private practice.

❑ No

❑ Yes, please state the anticipated month and year: _____(Month) /_____(Year)
(Clinic / Corporation: _____ ; Position: _____)

III. Applying Clinical Privilege *(please complete corresponding application form(s) as attachment in this application)*

Supplementary application forms	**Form no.**	**Clinical area to which the privilege(s) is/are applicable**
❑ Application for using Delivery Suite	Nil	Delivery Suite
❑ Application Form for Privilege –Plastic & Aesthetic Procedures	CHM-041	Plastic and Aesthetic Multidisciplinary Centre
❑ Application Form for Privilege – Renal Dialysis	CHM-042	Renal Dialysis Centre
❑ Application Form for Privilege – Reproductive Medicine Services	CHM-043	Union Reproductive Medicine Centre, Union Hospital Reproductive Medicine Centre (Tsim Sha Tsui)
❑ Application Form for Privilege – Laser Procedures	CHM-045	Operating Theatre, Endoscopy and Day Surgery Centre, Plastic and Aesthetic Multidisciplinary Centre, Heart Centre, Specialty Clinic
❑ Application Form for Privilege – Lung Function Diagnostic Services	CHM-046	Health Maintenance Centre
❑ Application Form for Privilege – Reporting Polysomnography(PSG), Continuous Positive Airway Pressure (CPAP) Titration and Multiple Sleep Latency Test (MSLT)	CHM-047	Ward 9
❑ Application Form for Privilege –Digital Subtraction Angiography / Interventional Radiology Procedures	CHM-048	Medical Imaging Department, Union Imaging & Healthcheck Centre, Cardiovascular Laboratory (Heart Centre)
❑ Application Form for Privilege – Procedures in Endoscopy (For Surgeon / G.I. / Family Physicians)	CHM-049	Endoscopy and Day Surgery Centre
❑ Application Form for Privilege –-Cardiology Procedures	CHM-050	Heart Centre
❑ Application Form for Privilege – Intensive Care Unit / High Dependency Unit	CHM-051	Intensive care unit / High dependency unit
❑ Application Form for Privilege – Surgical Procedures (OT)	CHM-052	Operating Theatre, Endoscopy and Day Surgery Centre, Plastic and Aesthetic Multidisciplinary Centre

IV. Education and Qualification *(Please provide only quotable qualifications and submit documentation proof)*

(in chronological order)		College / University	Degree or Qualification awarded	Country Issued	Office Use
From	To				

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❑Please ✓ as appropriate. * Mandatory field # Delete as appropriate

V. Employment History and Previous Experience

(in chronological order) From	To	Previous Employer	Position	Department / Unit

VI. Professional References

	Name of Referee	Position	Contact No.	Email address
A doctor who practices actively in Union Hospital				
A doctor in your specialty who may verify your experience/credentials				
A doctor who may assist you in adverse outcomes during course of clinical duties				

VII. Annual Practising Certificate (APC)

Registration No.: _____

Valid until (dd/mm/yyyy): _____

VIII. Professional Indemnity

Details of my Professional Indemnity Membership: #MPS / Other provider (specify) _____

Valid until (dd/mm/yyyy): _____

Category of indemnity: _____

I shall maintain my professional indemnity with adequate coverage appropriate to my scope of practice in private service. I confirm that I have valid professional indemnity with a professional indemnity provider(s) as the Hospital sees fit for as long as my admission right in Union Hospital is still effective.	❑ Yes ❑ No
I hereby authorize Union Hospital to obtain information from my professional indemnity provider(s) including the status, coverage and valid period for as long as my admission right in Union Hospital is still effective.	❑ Yes ❑ No

IX. License to Use an Irradiating Apparatus on Human Body

According to the Radiation Ordinance, a valid licence is required for personnel operating equipments with the use of ionizing radiation / radioactive materials and irradiating apparatus.
(For enquiry about application for this licence, please contact Manager of Medical Imaging Department at 2608 3898 for assistance.)

Will you use Mobile C-arms / X-Ray control during procedures in the following facilities?

❑ No

❑ Yes, please indicate ❑ Operating Theatre ❑ Digital Subtraction Angiography Suite ❑ Union Dental Centre

If Yes, Please provide the below information for the Irradiating Apparatus (IA) License from the Radiation Board:

License No: _____

Valid until (dd/mm/yyyy): _____

X. Applicant Release and Disclosure

Professional History

i) Have you ever been removed or refused from general or specialist medical registration to practice medicine in Hong Kong or other countries (including suspension of removal sentences)?
❑ No ❑ Yes, please specify: _____

ii) Have there ever been disciplinary or similar actions taken against you by the Medical Council of Hong Kong and/or similar medical registration bodies in other countries?
❑ No ❑ Yes, please specify: _____

iii) Have you ever lost a claim (either insured or uninsured) against you in the past related to professional services?
❑ No ❑ Yes, please specify: _____

iv) Have you ever been refused or withdrawn from visiting rights to any hospitals in Hong Kong or other countries?
❑ No ❑ Yes, please specify: _____

v) Have your clinical privileges at any hospital ever been suspended, diminished, revoked and/or not renewed?
❑ No ❑ Yes, please specify: _____

vi) Have you been subject of disciplinary in another local or overseas healthcare institution?
❑ No ❑ Yes, please specify: _____

vii) Have you had any event which may significantly affect suitability to practice medicine as an independent private doctor?
❑ No ❑ Yes, please specify: _____

Personal Record

viii) Do you have any of the following criminal convictions or information for consideration by Union Hospital in review of this application?

❑ No
❑ Criminal records ❑Civil records ❑Driver's license status ❑Credit reports
Please specify: _____

Health Status

ix) Do you have health condition(s) that carries significant chances to affect your professional services or clinical duties?
❑ No ❑ Yes, please specify: _____

x) Please answer the followings.
- You have immunity against ❑ Chickenpox ❑ Rubella ❑ Measles ❑ Mumps
- Are you having active tuberculosis? ❑ No ❑ Yes

xi) Do you need to do invasive procedures or operations?
❑ No ❑ Yes, please answer the followings.
- Are you a carrier of Hepatitis B? ❑ No ❑ Yes ❑ Don't know
- Are you a carrier of Hepatitis C? ❑ No ❑ Yes ❑ Don't know
- Do you have history of HIV (immunodeficiency virus) infection? ❑ No ❑ Yes

xii) Other relevant information
❑ No ❑ Yes, please specify: _____

XI. Supplemental Information (Attachments)

	Office Use
❑ Hong Kong Identify Card / Passport	❑
❑ Curriculum Vitae	❑
❑ Certificate of Registration under the Medical Registration Ordinance (Cap. 161)	❑
❑ Current Annual Practising Certificate (APC)	❑
❑ Current Membership Certificate of the Medical Protection Society (MPS) / other indemnity provider	❑
❑ Certificate of Specialist Registration (if applicable)	❑
❑ Current Irradiating Apparatus License (if applicable)	❑
❑ All other certificates of academic and medical qualifications mentioned in this application form	❑
❑ Letter of Authorization for HKMA and MPS (Notes: This will be sent to HKMA via email by Union Hospital only after your admission right at Union Hospital is granted.)	❑
❑ Bank Autopay Form	❑
❑ Business Registration Certificate (if applicable)	❑
❑ Copy of Bank Statement	❑
❑ Business Name Card	❑
❑ Recent Photo	❑
❑ Others _____	❑
Notes: *Upon receipt of all the required documents, this application will be vetted by hospital management. The process will take **about 12 weeks.***	

XII. Declaration

I hereby declare that all statements on this application and all attached forms are true and correct to the best of my knowledge. I understand that Union Hospital collects this information and may further solicit additional information so as to be informed of my previous personnel and professional record and character. I further understand and agree that any misrepresentation, falsification, or omission of facts by me may constitute to the disqualification to this application. I also understand and agree that granting of hospital privileges is at the full discretion of Union Hospital. I further agree and understand that any professional misconduct or criminal behavior may be considered in future review of my hospital privileges by Union Hospital.

I understand that the below signature and initials would be captured in Hospital Management Information System for verification of prescription orders and/or treatment on Progress/Treatment Sheets.

Name in BLOCK Letters					
Signature		Initials		Date	

XIII. Hospital Administration (For Hospital Use Only)

Deputy Medical Director (DMD) / Deputy Chief Hospital Manager (DCHM)

Comment	❑ Supported / ❑ Not supported		
Signature		Date	

Chief Hospital Manager & Medical Director (CHM & MD)

Comment	❑ Approved / ❑ Declined		
Signature		Date	

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❑Please ✓ as appropriate. * Mandatory field # Delete as appropriate