

Instruction Notes:

- (i) For new applicants (no existing admission right or clinical privilege in UH), please complete the form CHM-001 Application Form for Admission Right & Clinical Privileges and attach this form (+/- other privilege forms) as supplementary document(s).
- (ii) Please provide supporting evidence of relevant training and experience.
- (iii) Please submit completed application forms together with 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.

<u>For Hospital Use Only</u>
Date received: _____
App. Ref. No.: _____
Doctor’s code: _____

Please complete this form in BLOCK letters.

I. Personal Particulars

Doctor’s Name	Doctor’s Code in Union Hospital
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II. Training and Experience

Are you a registered Specialist in one of the following specialties?

Radiology Cardiology Orthopaedics
 Neurosurgery Anaesthetics Others, please specify _____
 No Yes, registration with _____

Are you a Fellow of the Hong Kong Academy of Medicine?

No Yes, since: _____

Have you ever been suspended or refused the privilege to practice to use the facilities of Digital Subtractive Angiography/Interventional Radiology Suite or Cardiac Catheterisation Laboratory in Hong Kong or overseas?

No Yes, please specify: _____

III. Previous training and experience (if relevant)

Institution 1		Supervisor	
Year		Email	
Institution 2		Supervisor	
Year		Email	

Remarks: supervisors may be contacted via mail or email to verify information of this application.

IV. Application for Privilege in Performing

<u>For Hospital Use Only</u>
Screened by: _____
Date: _____

	Applied	Granted	Remarks
<u>Vascular Procedures:</u>			
Peripheral Vascular (arterial)	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Peripheral Vascular (venous)	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	

(Cont’d)

Please ✓ as appropriate. * Please delete as appropriate.

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	Applied	Granted	Remarks
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Renal	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatobiliary	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Visceral	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Gynaecological	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Others, please specify	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Non-vascular Procedures:</u>			
Hepatobiliary (e.g. PTBD, biliary stent)	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Renal (e.g. Nephrostomy, ureteric stent)	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Others, please specify	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Please provide a list of procedures that you wish to perform in the Digital Subtractive Angiography /Interventional Radiology Suite at the Medical Imaging Department or Union Imaging & Healthcheck Centre or the Cardiovascular Laboratory (Heart Centre) of Union Hospital and the log of previous training/ work experience in the space below. Supplementary sheets or data files may be included with you application</p>			

Note: The privilege will be reviewed every 2 years.

Please ✓ as appropriate. * Please delete as appropriate.

V. Declaration

I declare that the information provided above is accurate and true.					
Name in BLOCK Letters		HKID No.			
Signature		Initials		Date	

VI. Internal Vetting (For Hospital Use Only)

Head of Medical Imaging Department

Comment	<input type="checkbox"/> Supported / <input type="checkbox"/> Not supported				
Signature		Date			

Deputy Medical Director (DMD)

Comment	<input type="checkbox"/> Supported / <input type="checkbox"/> Not supported				
Signature		Date			

Chief Hospital Manager & Medical Director

Comment	<input type="checkbox"/> Approved / <input type="checkbox"/> Declined				
Signature		Date			

VII. Administration (For Hospital Use Only)

Date of completing PMI Data Entry		Signature					
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Please ✓ as appropriate. * Please delete as appropriate.