

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.

For Hospital Use Only
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

<p>Are you a registered Specialist in Cardiology? <input type="checkbox"/> No <input type="checkbox"/> Yes, registration with: _____</p> <p>Are you a Fellow of the Hong Kong Academy of Medicine? <input type="checkbox"/> No <input type="checkbox"/> Yes, since: _____</p> <p>Have you ever been suspended or refused the privilege to use the facilities of the Cardiac Catheterization Laboratory in Hong Kong or overseas? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify: _____</p>

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 & Reporting

For Hospital Use Only
Screened by: _____
Date: _____

	Applied	Granted	Remarks
Treadmill Exercise	<input type="checkbox"/>	<input type="checkbox"/>	
Treadmill Exercise for standby only, reporting must be done by cardiologist	<input type="checkbox"/>	<input type="checkbox"/>	
Echocardiogram (Transthoraxis)	<input type="checkbox"/>	<input type="checkbox"/>	
Echocardiogram (Transoesophageal)	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Echocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	
Tilt Table Test	<input type="checkbox"/>	<input type="checkbox"/>	
Tilt Table Test for standby only, reporting must be done by cardiologist	<input type="checkbox"/>	<input type="checkbox"/>	

(Cont’d)

Please ✓ as appropriate. * Please delete as appropriate.

	For Hospital Use Only		
	Applied	Granted	Remarks
Holter ECG and Cardiac Event	<input type="checkbox"/>	<input type="checkbox"/>	
CV Lab procedures	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Intervention	<input type="checkbox"/>	<input type="checkbox"/>	
EPS & RF	<input type="checkbox"/>	<input type="checkbox"/>	
Implantation of pacemaker / ICD	<input type="checkbox"/>	<input type="checkbox"/>	
Other Procedures	<input type="checkbox"/>	<input type="checkbox"/>	
Peripheral and Vascular	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<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"/>	
Interventional	<input type="checkbox"/>	<input type="checkbox"/>	
Minor Operation	<input type="checkbox"/>	<input type="checkbox"/>	
Provision of log of previous training / work experience in these areas will be appreciated	<input type="checkbox"/>	<input type="checkbox"/>	

Note: The privilege will be reviewed every 2 years.

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)

Director of Heart Centre

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.