

UNION HOSPITAL

Doctor Liaison Office

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 IV 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 Doctor Liaison Office, 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 Doctor Liaison Office at 2608 3125 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				<div style="border: 1px solid black; padding: 20px; width: 150px; margin: auto;"> RECENT PHOTO </div>
*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)		<i>For emergency contact</i>	
*Mobile No. (with SMS and instant messaging)	Can the number be disclosed to patients on business card? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>For communication with UH staff related to patient management. Information will be disclosed in Hospital Intranet, Telephone Directory and Clinical Management Programs</i>	
*E-mail				
*Correspondence Address <i>(For posting of all documents, bills and reports of the hospital)</i>				

II. Current Practice

#Private Practice / Institution		since (year)	
Position			
Address			
Office Tel. No.		Fax No.	
For applicant currently <u>working in public institutes</u> , please indicate below whether you are planning to set up private practice.			
<input type="checkbox"/> No			
<input type="checkbox"/> Yes, please state the anticipated month and year: _____ (Month) / _____ (Year) (Clinic / Corporation: _____ ; Position: _____)			

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

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
<input type="checkbox"/> Application for using Delivery Suite	Nil	Delivery Suite
<input type="checkbox"/> Application Form for Privilege –Plastic & Aesthetic Procedures	CHM-041	Plastic and Aesthetic Multidisciplinary Centre
<input type="checkbox"/> Application Form for Privilege – Renal Dialysis	CHM-042	Renal Dialysis Centre
<input type="checkbox"/> Application Form for Privilege – Reproductive Medicine Services	CHM-043	Union Reproductive Medicine Centre, Union Hospital Reproductive Medicine Centre (Tsim Sha Tsui)
<input type="checkbox"/> Application Form for Privilege – Laser Procedures	CHM-045	Operating Theatre, Endoscopy and Day Surgery Centre, Plastic and Aesthetic Multidisciplinary Centre, Heart Centre, Specialty Clinic
<input type="checkbox"/> Application Form for Privilege – Lung Function Diagnostic Services	CHM-046	Health Maintenance Centre
<input type="checkbox"/> Application Form for Privilege – Reporting Polysomnography(PSG), Continuous Positive Airway Pressure (CPAP) Titration and Multiple Sleep Latency Test (MSLT)	CHM-047	Ward 9
<input type="checkbox"/> Application Form for Privilege –Digital Subtraction Angiography / Interventional Radiology Procedures	CHM-048	Medical Imaging Department, Union Imaging & Healthcheck Centre, Cardiovascular Laboratory (Heart Centre)
<input type="checkbox"/> Application Form for Privilege – Procedures in Endoscopy (For Surgeon / G.I. / Family Physicians)	CHM-049	Endoscopy and Day Surgery Centre
<input type="checkbox"/> Application Form for Privilege –Cardiology Procedures	CHM-050	Heart Centre
<input type="checkbox"/> Application Form for Privilege – Intensive Care Unit / High Dependency Unit	CHM-051	Intensive care unit / High dependency unit
<input type="checkbox"/> 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				

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

V. Employment History and Previous Experience

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

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): _____

CHM-001-21-729(R22)

X. Applicant Release and DisclosureProfessional 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
<input type="checkbox"/> Hong Kong Identify Card / Passport	<input type="checkbox"/>
<input type="checkbox"/> Curriculum Vitae	<input type="checkbox"/>
<input type="checkbox"/> Certificate of Registration under the Medical Registration Ordinance (Cap. 161)	<input type="checkbox"/>
<input type="checkbox"/> Current Annual Practising Certificate (APC)	<input type="checkbox"/>
<input type="checkbox"/> Current Membership Certificate of the Medical Protection Society (MPS) / other indemnity provider	<input type="checkbox"/>
<input type="checkbox"/> Certificate of Specialist Registration (if applicable)	<input type="checkbox"/>
<input type="checkbox"/> Current Irradiating Apparatus License (if applicable)	<input type="checkbox"/>
<input type="checkbox"/> All other certificates of academic and medical qualifications mentioned in this application form	<input type="checkbox"/>
<input type="checkbox"/> Bank Autopay Form	<input type="checkbox"/>
<input type="checkbox"/> Business Registration Certificate (if applicable)	<input type="checkbox"/>
<input type="checkbox"/> Copy of Bank Statement	<input type="checkbox"/>
<input type="checkbox"/> Business Name Card	<input type="checkbox"/>
<input type="checkbox"/> Recent Photo	<input type="checkbox"/>
<input type="checkbox"/> Others _____	<input type="checkbox"/>
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	<input type="checkbox"/> Supported / <input type="checkbox"/> Not supported				
Signature		Date			

Chief Hospital Manager & Medical Director (CHM & MD)

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

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