UNION HOSPITAL

HMA Department **Application Form for Privilege – Renal Dialysis**

Instruction Notes:

(i) For new applicants (without 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	

II. Training and Experience in Renal Dialysis

Are you a registered Specialist?
❑ No ❑ Yes, registration with _____

Are you a Fellow of the Hong Kong Academy of Medicine?
❑ No ❑ Yes, since: _____

Have you got any fellowship in Nephrology?
❑ No ❑ Yes, since: _____

Have you got any fellowship in internal medicine?
❑ No ❑ Yes, since: _____

Have you ever been granted the privilege of renal dialysis in Hong Kong or overseas?
❑ No ❑ Yes, please list: _____

Have you ever been suspended or refused the privilege of renal dialysis 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 admission privilege for different patient groups

❑ Adult patients ❑ Paediatric patients

Note: The privilege will be reviewed every 2 years.

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❑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)

Director of Renal Dialysis Centre / Head of Department of Internal Medicine

Comment	❑ Supported / ❑ Not supported		
Signature		Date	

Deputy Medical Director (DMD)

Comment	❑ Supported / ❑ Not supported		
Signature		Date	

Chief Hospital Manager & Medical Director

Comment	❑ Approved / ❑ 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.