

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 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.

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 Gastroenterology or Surgery?
 No Yes, registration with: _____

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

Have you ever been granted the privilege to practice in any Endoscopy Centre in Hong Kong or overseas?
 No Yes, please specify: _____

Have you ever been suspended or refused the privilege to practice in any Endoscopy Centre 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

For Hospital Use Only

Screened by: _____

Date: _____

	Applied	Granted	Remarks
<u>OGD:</u>			
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Therapeutic	<input type="checkbox"/>	<input type="checkbox"/>	
Insertion of BIB	<input type="checkbox"/>	<input type="checkbox"/>	
Insertion of PEG	<input type="checkbox"/>	<input type="checkbox"/>	
Hemostasis	<input type="checkbox"/>	<input type="checkbox"/>	
Banding of Oesophageal varices	<input type="checkbox"/>	<input type="checkbox"/>	
Polypectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Endoscopic Submucosal Dissection	<input type="checkbox"/>	<input type="checkbox"/>	

(Cont’d)

Please ✓ as appropriate. * Please delete as appropriate.

CHM-049-20-3129 (R4)

UNION HOSPITAL

Doctor Liaison Office

Application Form for Privilege – Procedures in Endoscopy (For Surgeon / G.I. / Family Physicians)

	<u>For Hospital Use Only</u>		
	Applied	Granted	Remarks
<u>Colonoscopy:</u>			
Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	
Therapeutic	<input type="checkbox"/>	<input type="checkbox"/>	
Hemostasis	<input type="checkbox"/>	<input type="checkbox"/>	
Polypectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Endoscopic Submucosal Dissection <i>Please provide supplementary information in Section IVa</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Endoscopy / Other procedures:</u>			
Diagnostic Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Laryngoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Nasopharyngoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
ERCP <i>Please provide supplementary information in Section IVa</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Small Bowel Enteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Rigid Cystoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Flexible Cystoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Capsule Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Endobronchial Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	
Endoscopic Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	
Provision of log of previous training / working experience in the above application areas will be appreciated.	<input type="checkbox"/>	<input type="checkbox"/>	

Section IVa: Supplementary Information for Endoscopic Submucosal Dissection and ERCP (as appropriate)

Please provide supporting evidence of relevant training and experience.

	No. of case performed in the past 5 years	Independent or Under supervision *
Endoscopic Submucosal Dissection		Independent / Under supervision
ERCP		Independent / Under supervision

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

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Please ✓ as appropriate. * Please delete as appropriate.

VI. Internal Vetting (For Hospital Use Only)

Head of G.I. and Liver 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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