

### Instruction Notes:

- 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).
- Please provide supporting evidence of relevant training and experience.
- 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.
- 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](mailto:vms@union.org).
- 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?

☐ No ☐ Yes, registration with: \_\_\_\_\_

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

☐ No ☐ Yes, since: \_\_\_\_\_

Have you got any fellowship in intensive care medicine or critical care medicine?

☐ No ☐ Yes, since: \_\_\_\_\_

Have you ever been granted the privilege of ICU admission in Hong Kong or overseas?

☐ No ☐ Yes, please list: \_\_\_\_\_

Have you ever been suspended or refused the privilege of ICU admission 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

### For Hospital Use Only

Screened by: \_\_\_\_\_

Date: \_\_\_\_\_

	Applied	Granted	Remarks
<u>Medical patient</u>			
High dependency care without need of invasive haemodynamic and respiratory support	<input type="checkbox"/>	<input type="checkbox"/>	
Intensive care with need of invasive respiratory support	<input type="checkbox"/>	<input type="checkbox"/>	
Intensive care with multi-organ support	<input type="checkbox"/>	<input type="checkbox"/>	

(Cont'd)

☐ Please ✓ as appropriate. \* Please delete as appropriate.

	For Hospital Use Only		
	Applied	Granted	Remarks
<u>General surgical patients</u>			
High dependency care without need of invasive haemodynamic and respiratory support	<input type="checkbox"/>	<input type="checkbox"/>	
Intensive care with need of invasive respiratory support	<input type="checkbox"/>	<input type="checkbox"/>	
Intensive care with multi-organ support	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Neurosurgical Patients</u>			
Perioperative neurosurgical intensive care	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Cardiothoracic Surgical Patients</u>			
Perioperative cardiothoracic intensive care	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Obstetrics and Gynaecology Patients</u>			
High dependency care without need of invasive haemodynamic and respiratory support	<input type="checkbox"/>	<input type="checkbox"/>	
Intensive care with need of invasive respiratory support	<input type="checkbox"/>	<input type="checkbox"/>	
Intensive care with multi-organ support	<input type="checkbox"/>	<input type="checkbox"/>	

*Note: The privilege will be reviewed every 2 years.*

Please note that specialists are automatically granted privileges to take charge of their own patient in the first 24 hours of admission to ICU, for a medical problem related to his/her own specialty or extended postoperative care. Active engagement of a specialist in intensive care/doctor with appropriate exposure is expected as part of good care.

### V. Declaration

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

### VI. Internal Vetting (For Hospital Use Only)

#### Head of ICU/HDU

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.