UNION HOSPITAL

Doctor Liaison Office **Application Form for Privilege – Laser Procedures**

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	

II. Training and Experience

Are you a registered Specialist?

❑ No

❑ Yes, registration with ❑ Ophthalmology ❑ Dermatology
❑ ENT ❑ Aesthetic/Plastic
❑ Urology ❑ Gynaecology
❑ Others: _____

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 laser procedures in hospital / laser centre in Hong Kong or overseas?

❑ No ❑ Yes, please list: _____

Have you ever been suspended or refused the privilege to practice in any hospital / laser centre in Hong Kong or overseas?

❑ No ❑ Yes, please specify:_____

III. Previous training and experience

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 Laser Procedure

For Hospital Use Only
Screened by:
Date:

	Applied	Granted	Remarks
Ophthalmology	❑	❑	
Dermatology	❑	❑	
ENT	❑	❑	
Aesthetic/Plastic	❑	❑	

(Cont'd)

❑Please ✓ as appropriate. * Please delete as appropriate.

		For Hospital Use Only	
	Applied	**Granted**	**Remarks**
Urology	❑	❑	
Gynaecology	❑	❑	
Others, please specify: _____	❑	❑	

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 (<u>For Hospital Use Only</u>)

Laser Safety Officer

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 (<u>For Hospital Use Only</u>)

Date of completing PMI Data Entry		Signature					

CHM-045-20-3125(R3)

❑Please ✓ as appropriate. * Please delete as appropriate.