UNION HOSPITAL

Doctor Liaison Office

Application Form for Privilege – Reporting Polysomnography(PSG), Continuous Positive Airway Pressure (CPAP) Titration and Multiple Sleep Latency Test (MSLT)

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 in Respiratory Medicine / Otorhinolaryngology?
❑ No ❑ Yes, registration with:_____

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

Please provide other relevant qualification (use supplementary sheets if necessary)
_____

Have you ever been suspended or refused the privilege in reporting PSG, CPAP Titration and MSLT in Sleep Centre of Hong Kong or overseas?
❑ No ❑ Yes, please specify:

Please provide the log of previous training / work experience in reporting PSG, CPAP Titration and MSLT.

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 Reporting

For Hospital Use Only Screened by: Date:			
	Applied	**Granted**	**Remarks**
Polysomnography (PSG)	❑	❑	
Continuous Positive Airway Pressure (CPAP) Titration	❑	❑	
Multiple Sleep Latency Test (MSLT)	❑	❑	

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)

Centre Director / Head of Department of Internal Medicine / Head of Outpatient Services

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					