UNION HOSPITAL

Doctor Liaison Office **Application Form for Privilege – Digital Subtraction Angiography / Interventional Radiology Procedures**

For Hospital Use Only
Date received: ____________
App. Ref. No.:____________
Doctor's code:____________

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.

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 one of the following specialties?
❑ Radiology ❑ Cardiology ❑ Orthopaedics
❑ Neurosurgery ❑ Anaesthetics ❑ Others, please specify______________________________
❑ No ❑ Yes, registration with________________________________

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

Have you ever been suspended or refused the privilege to practice to use the facilities of Digital Subtractive Angiography/Interventional Radiology Suite or Cardiac Catheterisation Laboratory 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**
Vascular Procedures:			
Peripheral Vascular (arterial)	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Peripheral Vascular (venous)	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	

(Cont'd)

CHM-048-21-3128 (R6)

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

		For Hospital Use Only	
	Applied	**Granted**	**Remarks**
Neurological	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Renal	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Hepatobiliary	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Visceral	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Gynaecological	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Others, please specify	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Non-vascular Procedures:			
Hepatobiliary (e.g. PTBD, biliary stent)	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Renal (e.g. Nephrostomy, ureteric stent)	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Gastrointestinal	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Musculoskeletal	❑	❑	
Diagnostic	❑	❑	
Interventional	❑	❑	
Others, please specify	❑	❑	

Please provide a list of procedures that you wish to perform in the Digital Subtractive Angiography /Interventional Radiology Suite at the Medical Imaging Department or Union Imaging & Healthcheck Centre or the Cardiovascular Laboratory (Heart Centre) of Union Hospital and the log of previous training/ work experience in the space below. Supplementary sheets or data files may be included with you application

Note: The privilege will be reviewed every 2 years.

CHM-048-21-3128 (R6)

❑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 (<u>For Hospital Use Only</u>)

Head of Medical Imaging Department

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-048-21-3128 (R6)

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