# UNION HOSPITAL

**Doctor Liaison Office**

**Application Form for Privilege – Intensive Care Unit / High Dependency Unit**

**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: _____

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 |
|---|---|---|---|
| *Medical patient* | | | |
| High dependency care without need of invasive haemodynamic and respiratory support | ❑ | ❑ | |
| Intensive care with need of invasive respiratory support | ❑ | ❑ | |
| Intensive care with multi-organ support | ❑ | ❑ | |

(Cont'd)

CHM-051-20-3131 (R3)

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

| | | For Hospital Use Only | |
|---|---|---|---|
| | **Applied** | **Granted** | **Remarks** |
| *General surgical patients* | | | |
| High dependency care without need of invasive haemodynamic and respiratory support | ❑ | ❑ | |
| Intensive care with need of invasive respiratory support | ❑ | ❑ | |
| Intensive care with multi-organ support | ❑ | ❑ | |
| *Neurosurgical Patients* | | | |
| Perioperative neurosurgical intensive care | ❑ | ❑ | |
| *Cardiothoracic Surgical Patients* | | | |
| Perioperative cardiothoracic intensive care | ❑ | ❑ | |
| *Obstetrics and Gynaecology Patients* | | | |
| High dependency care without need of invasive haemodynamic and respiratory support | ❑ | ❑ | |
| Intensive care with need of invasive respiratory support | ❑ | ❑ | |
| Intensive care with multi-organ support | ❑ | ❑ | |

*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

| **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)

**Head of ICU/HDU**

| 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 | | | | | |
|---|---|---|---|---|---|---|---|

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