

HONG KONG SANATORIUM & HOSPITAL

養和醫院

2 Village Road, Happy Valley, Hong Kong

Tel: (852) 2572 0211 Fax: (852) 2835 8008

Web site : www.hksh.com

## Application Form for Hospital Privileges

### Explanatory Notes

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Please attach copies of:

- 1. H.K. Identity Card
  - 2. Certificate of Registration (HKMC/HKDC)
  - 3. Current H.K. Annual Practising Certificate
  - 4. University and Post-graduate Diploma
  - 5. Curriculum Vitae
  - 6. Current Medical Indemnity Insurance Certificate
  - 7. Specialist Registration Certificate
  - 8. Two References & Two Reference Forms
- .....

1. Please tick only items of Hospital Privileges you will use regularly.  
For applications of privileges for procedures (items 3 – 13) please provide supporting evidence of related training and experience.
2. The Hospital reserves the right to grant particular types of privileges.
3. All approved privileges are subject to review by the Hospital.
4. Please provide a copy each of your Annual Practising Certificate and Medical Indemnity Insurance Certificate to the Hospital after renewal every year.
5. Please notify the Hospital of any changes of information.

(For Hospital use only)

Name of applicant

Ref. No. \_\_\_\_\_

**Hospital Privileges applied for:** (Please tick only items applicable)

- |  |  |
|--|--|
| <input type="checkbox"/> 1. Admission of Patients  | <input type="checkbox"/> 11. Endoscopy : ERCP  |
| <input type="checkbox"/> 2. Anaesthesiology  | <input type="checkbox"/> 12. Cardiac Catheterisation & Intervention                      |
| <input type="checkbox"/> 3. OT : Surgical procedures relating to specialty / training <sup>I</sup>                     | <input type="checkbox"/> 13. Lithotripsy   |
| <input type="checkbox"/> 4. OT : Minimally invasive surgical procedures relating to specialty / training <sup>II</sup> | <input type="checkbox"/> 14. Plastic & Reconstruction Centre <sup>V</sup>                |
| <input type="checkbox"/> 5. OT : Minor surgical procedures <sup>III</sup>  | <input type="checkbox"/> 15. Maternity   |
| <input type="checkbox"/> 6. OT : Robotic assisted surgical procedures <sup>IV</sup>                                    | <input type="checkbox"/> 16. Invitro-Fertilisation <sup>VI</sup>                         |
| <input type="checkbox"/> 7. OT : Specified Procedures _____ (Please specify)   | <input type="checkbox"/> 17. Radiotherapy  |
| <input type="checkbox"/> 8. Endoscopy : Bronchoscopy   | <input type="checkbox"/> 18. Haemodialysis & peritoneal dialysis                         |
| <input type="checkbox"/> 9. Endoscopy : Gastroscopy  | <input type="checkbox"/> 19. Focused Ultrasound (for gynaecologists only) <sup>VII</sup> |
| <input type="checkbox"/> 10. Endoscopy : Colonoscopy   | <input type="checkbox"/> 20. Refractive Surgery (LASIK) <sup>VIII</sup>                  |
|  | <input type="checkbox"/> 21. ICU <sup>IX</sup>   |

(Please see explanatory notes at back page)

.....

Name \_\_\_\_\_  
 (Block Letters - Surname, Given Name) (In Chinese)

Sex: F / M Date of Birth : \_\_\_\_\_(DD/MM/YY)

H.K.I.D. Card No. \_\_\_\_\_ ( )

Marital Status: Single / Married / Divorced

Name of Spouse: (Mr./Ms./Dr./Prof.) \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Pager: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact Info. (for personal matters):

Name \_\_\_\_\_ Contact No.: \_\_\_\_\_

Attach  
recent  
photo

**Alternative Contact** In case I am not available for urgent clinical attendance

(1) Refer the patient to a designated doctor: Dr.'s Name \_\_\_\_\_  
 Contact No. \_\_\_\_\_

(The designated doctor should have our Hospital Privileges and with the same specialty as the applicant)

(2) Refer the patient to Hospital designated doctor \* **Option (2) will be chosen by default if not answered**

**Please indicate your preference for correspondence address**

\* **Option (1) will be chosen as correspondence address by default if not answered**

(1) Office Address  as correspondence address Telephone \_\_\_\_\_ Fax \_\_\_\_\_

(2) Residential Address  as correspondence address Telephone \_\_\_\_\_ Fax \_\_\_\_\_

**Education Information**

1. University from which graduated \_\_\_\_\_  
 Year of graduation \_\_\_\_\_ Degree \_\_\_\_\_

2. Year of first registration with Medical/Dental Council of Hong Kong \_\_\_\_\_  
 Medical / Dental Council Registration No. \_\_\_\_\_  
 Qualification used for primary registration: \_\_\_\_\_

3. Other Quotable Qualifications (with dates) :

Qualifications	Year	Qualifications	Year

4. Practicing Specialty: \_\_\_\_\_

<p style="text-align: center;"><u>Medical/ Dental Council of Hong Kong</u> <u>Specialist Registration:</u></p> <p>Registered in: _____ (Specialty)</p> <p>Specialist Registration No: _____</p>	<p style="text-align: center;"><u>Other Specialist Registration:</u></p> <p>Registered with: _____ (Institution)</p> <p>Registered in: _____ (Specialty)</p> <p>Specialist Registration No: _____</p>
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5. Fellow of Hong Kong Academy of Medicine: (Specialty) \_\_\_\_\_

6. Medical Indemnity Insurance: \*MPS/Other No. : \_\_\_\_\_ Expiry Date: \_\_\_\_\_  
 (DD/MM/YY)

MPS Subscription rate information:

Risk: (HGI / HGM / HKS / HKC / MOB / COS / SHS / VHR / MHR / MMR / MLR/ PGZ / PGP / PGO / XGP or others: \_\_\_\_\_) <sup>IX</sup>

(\*Please delete as appropriate)

7. Current Appointment: \_\_\_\_\_

8. Two References: \_\_\_\_\_

9. Expected Hospital Privileges effective date: \_\_\_\_\_  
 (Remarks: Application processing normally takes 6-8 weeks)

(\*Please use separate sheet if required)

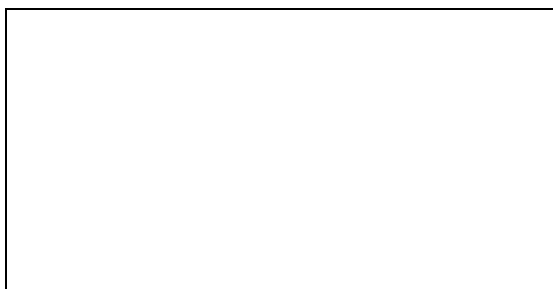
# UNDERTAKING

## Terms & Conditions of Granting of Hospital Privileges

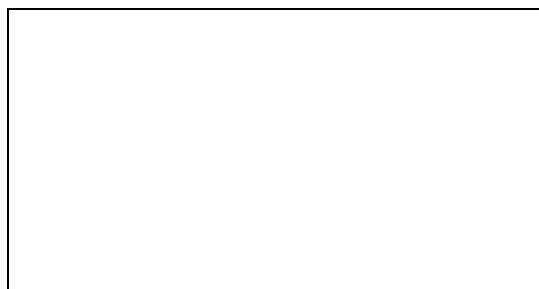
The approval of application for Hospital Privileges is subject to the following “Terms & Conditions” as may be revised from time to time by the Hospital (“HKSH”). HKSH may, at any time revise these Terms & Conditions without prior notice. Doctors practising in the Hospital are bound by such revision as soon as they are posted on our Hospital’s website. Doctors are advised to review these Terms & Conditions regularly.

- Doctors should undertake to maintain at all times during his/her practice in the Hospital, at their own expense, an effective medical indemnity insurance. If at any time he / she ceases to be covered by such valid professional indemnity insurance, he / she will notify the Hospital immediately.
- Doctors should abide by the “Code of Practice” compiled and approved by Private Hospitals Association and relevant directives issued by the Department of Health.
- To enhance the quality of care and the delivery of safe practice in the Hospital, Doctors with hospital privileges must give consent to HKSH to select their cases for presentations at the Hospital’s Mortality & Morbidity Meetings, and for the compilation of audit reports. In these circumstances, patients and doctors identities will not be revealed.

I, hereby sign and confirm that I am aware of the above terms and conditions of granting of hospital privileges at HKSH and that I am physically and mentally fit for the practice of medicine. I have perused this agreement in full before signing it. I understand that the Hospital reserves the right to suspend or withdraw privileges granted to me.



**Signature**



**Initial**

Note : A doctor’s specimen signature and initials are used by Hospital staff for verification. Please sign with black ink.

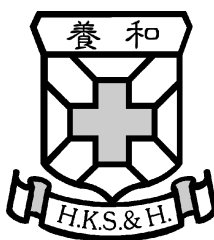
Date (DD/MM/YY) \_\_\_\_\_

**Explanatory Notes**

- I OT: operation privileges are granted in accordance with the specialty / training of the Doctor.
- II OT: minimally invasive surgical privileges are granted in accordance with the specialty & training of the doctor.  
For gynaecology – there are 2 levels, Intermediate & Advanced.
- III Application for Item 5 is not required, if applying for Item 3.
- IV Supplementary application is required. There are 2 levels, Provisional & Full.
- V Supplementary application is required.
- VI IVF(male procedures) granted to urologists upon application.
- VII Supplementary application is required.
- VIII Supplementary application is required.
- IX Applicants should have proper training and adequate experience in management of acute critical diseases in their field and they must accept, acknowledge, and abide by the Admission and Discharge Guideline for ICU of the Hospital.
- X Government and Hospital Authority Rates:  
HGI: Intern; HGM: Medical Officer / Medical Officer Trainee / Assistant Professor; HKS: Senior Medical Officer / Specialist / Associate Professor; HKC: Consultant / Professor / Director  
Private Hospital Rates:  
MOB: Obstetrics; COS Cosmetic / aesthetic practice; SHS: Super High Risk; VHR: Very High Risk; MHR: High Risk; MMR: Medium Risk; MLR: Low Risk; PGZ: GP Non Procedural; PGP: GP Procedural; PGO: GP Risk with obstetrics; XGP: Cosmetic and Aesthetic Medicine

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<b>(For Hospital Use Only)</b>	<u>Approved</u>	<u>Remarks</u>
<input type="checkbox"/> 1. Admission of Patients	1. <input type="checkbox"/>	
<input type="checkbox"/> 2. Anaesthesiology	2. <input type="checkbox"/>	
<input type="checkbox"/> 3. OT : Surgical procedures relating to specialty / training	3. <input type="checkbox"/>	
<input type="checkbox"/> 4. OT : Minimally invasive surgical procedures relating to specialty / training	4. <input type="checkbox"/>	
<input type="checkbox"/> 5. OT : Minor surgical procedures	5. <input type="checkbox"/>	
<input type="checkbox"/> 6. OT : Robotic assisted surgical procedures	6. <input type="checkbox"/>	
<input type="checkbox"/> 7. OT : Specified Procedures _____ (please specify)	7. <input type="checkbox"/>	
<input type="checkbox"/> 8. Endoscopy : Bronchoscopy	8. <input type="checkbox"/>	
<input type="checkbox"/> 9. Endoscopy : Gastroscopy	9. <input type="checkbox"/>	
<input type="checkbox"/> 10. Endoscopy : Colonoscopy	10. <input type="checkbox"/>	
<input type="checkbox"/> 11. Endoscopy : ERCP	11. <input type="checkbox"/>	
<input type="checkbox"/> 12. Cardiac Catheterisation & Intervention	12. <input type="checkbox"/>	
<input type="checkbox"/> 13. Lithotripsy	13. <input type="checkbox"/>	
<input type="checkbox"/> 14. Plastic & Reconstruction Centre	14. <input type="checkbox"/>	
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<input type="checkbox"/> 20. Refractive Surgery (LASIK)	20. <input type="checkbox"/>	
<input type="checkbox"/> 21. ICU	21. <input type="checkbox"/>	
Practising Specialty: _____		
<u>Approved by:</u>	Designated member of Hospital Privileges Subcommittee	Signature
		Date



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## REFERENCE FORM

I am applying for the hospital privileges at Hong Kong Sanatorium & Hospital. The Hospital requires this reference form to be completed together with your reference letter as part of my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Hong Kong Sanatorium & Hospital at the above address.

Print / Type Full Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL PROVIDING THE REFERENCE

Please Note: References must be typed or printed clearly. Illegible references may delay the application

#### EVALUATION

*Based upon demonstrated performance and composite of evaluations by supervisors on file.*

	Superior	Satisfactory	Unsatisfactory	No Information
Basic Clinical Knowledge				
Professional Judgment				
Clinical Competence and Skill				
Reliability / Sense of Responsibility				
Patient Management				
Ethical Conduct				
Physician – Patient Relationship				
Ability to Work with Other Hospital Staff				
Appearance				
Medical Recordkeeping				
Ability to Communicate Verbally				
<b>OVERALL RATING:</b>				

**Recommendation:**

- Recommended Highly without Reservation   
  Recommended as Qualified and Competent  
 Recommended with Reservation   
  No Comment / Not Recommended

Additional Comments (*Use reverse side if necessary*):

Printed name of Referee \_\_\_\_\_

Signature \_\_\_\_\_

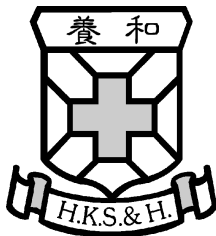
Title \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Please Affix  
Department,  
Hospital, or  
Notarial Seal  
Here

*Please return directly to HKSH at the above address. Thank you for your prompt cooperation.*



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Ability to Communicate Verbally				
<b>OVERALL RATING:</b>				

**Recommendation:**

- Recommended Highly without Reservation   
  Recommended as Qualified and Competent  
 Recommended with Reservation   
  No Comment / Not Recommended

Additional Comments (*Use reverse side if necessary*):

Printed name of Referee

Signature

Title

Date

Relationship to Applicant

Please Affix  
Department,  
Hospital, or  
Notarial Seal  
Here

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