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

Please attach copies of:

- ❑ 1. H.K. Identity Card
- ❑ 2. Certificate of Registration (HKMC/HKDC)
- ❑ 3. Current H.K. Annual Practicing Certificate
- ❑ 4. University and Post-graduate Diploma
- ❑ 5. Curriculum Vitae
- ❑ 6. Current Malpractice 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 Malpractice 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)

- ❑ 1.Admission of Patients
- ❑ 2.Anaesthesiology
- ❑ 3.OT : Surgical procedures relating to specialty / training [I]
- ❑ 4.OT : Minimally invasive surgical procedures relating to specialty / training [II]
- ❑ 5.OT : Minor surgical procedures [III]
- ❑ 6.OT : Robotic assisted surgical procedures [IV]
- ❑ 7.OT : Specified Procedures ____________________________ (Please specify)
- ❑ 8.Endoscopy : Bronchoscopy
- ❑ 9.Endoscopy : Gastroscopy
- ❑ 10.Endoscopy : Colonoscopy

(*Please see explanatory notes at back page*)

- ❑ 11. Endoscopy : ERCP
- ❑ 12. Cardiac Catheterisation & Intervention
- ❑ 13. Lithotripsy
- ❑ 14. Plastic & Reconstruction Centre [V]
- ❑ 15. Maternity
- ❑ 16. Invitro-Fertilisation [VI]
- ❑ 17. Radiotherapy
- ❑ 18. Haemodialysis & peritoneal dialysis
- ❑ 19. Focused Ultrasound (for gynaecologists only) [VII]
- ❑ 20. Refractive Surgery (LASIK) [VIII]

Name ____

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

Attach recent photo

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.: ______________________________

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: ____________________

Medical/ Dental Council of Hong Kong Specialist Registration: Registered in: ____________ (Specialty) Specialist Registration No: ____________	Other Specialist Registration: Registered with: ____________ (Institution) Registered in: ____________ (Specialty) Specialist Registration No: ____________

5. Fellow of Hong Kong Academy of Medicine: (Specialty) ____________________

6. Malpractice 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: ____________________) IX
   (*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

(Please tick ❑ as appropriate)

I undertake to maintain at all times during my practice in the Hospital, at my own expense, an effective policy of insurance for medical malpractice. If at any time I shall cease to be covered by such valid professional indemnity insurance, I will notify the Hospital immediately.

❑ Yes ❑ No

I understand that the Hospital reserves the right to suspend or withdraw privileges granted to me.

❑ Yes ❑ No

I agree to abide by the "Code of Practice of the Private Hospitals Association" promulgated by the Hong Kong Private Hospitals Association.

❑ Yes ❑ No

Signature

Initial

Note : A doctors' 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 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;

(For Hospital Use Only)

	Item	Approved	Remarks
☐	1. Admission of Patients	1. ☐	______
☐	2. Anaesthesiology	2. ☐	______
☐	3. OT : Surgical procedures relating to specialty / training	3. ☐	______
☐	4. OT : Minimally invasive surgical procedures relating to specialty / training	4. ☐	______
☐	5. OT : Minor surgical procedures	5. ☐	______
☐	6. OT : Robotic assisted surgical procedures	6. ☐	______
☐	7. OT : Specified Procedures ______________(please specify)	7. ☐	______
☐	8. Endoscopy : Bronchoscopy	8. ☐	______
☐	9. Endoscopy : Gastroscopy	9. ☐	______
☐	10. Endoscopy : Colonoscopy	10. ☐	______
☐	11. Endoscopy : ERCP	11. ☐	______
☐	12. Cardiac Catheterisation & Intervention	12. ☐	______
☐	13. Lithotripsy	13. ☐	______
☐	14. Plastic & Reconstruction Centre	14. ☐	______
☐	15. Maternity	15. ☐	______
☐	16. Invitro-Fertilisation	16. ☐	______
☐	17. Radiotherapy	17. ☐	______
☐	18. Haemodialysis & peritoneal dialysis	18. ☐	______
☐	19. Focused Ultrasound (for gynaecologists only)	19. ☐	______
☐	20. Refractive Surgery (LASIK)	20. ☐	______

Practising Specialty: ______________________________

Approved by:

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				
OVERALL RATING:				

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.