



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 Malpractice Insurance Certificate
 - 7. Specialist Registration Certificate
 - 8. Two References & Two Reference Forms
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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.

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|----------------------------|
| (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 ^I | <input type="checkbox"/> 13. Lithotripsy |
| <input type="checkbox"/> 4. OT : Minimally invasive surgical procedures relating to specialty / training ^{II} | <input type="checkbox"/> 14. Plastic & Reconstruction Centre ^V |
| <input type="checkbox"/> 5. OT : Minor surgical procedures ^{III} | <input type="checkbox"/> 15. Maternity |
| <input type="checkbox"/> 6. OT : Robotic assisted surgical procedures ^{IV} | <input type="checkbox"/> 16. Invitro-Fertilisation ^{VI} |
| <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) ^{VII} |
| <input type="checkbox"/> 10. Endoscopy : Colonoscopy (Please see explanatory notes at back page) | <input type="checkbox"/> 20. Refractive Surgery (LASIK) ^{VIII} |

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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.: _____

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**

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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: _____

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

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 policy of insurance for medical malpractice. If at any time he / she shall cease to be covered by such valid professional indemnity insurance, he / she will notify the Hospital immediately.
- Doctors should be abided by the “Code of Practice” and relevant directives issued by the Department of Health.
- To enhance the quality of care and the delivery of safe standard of practice in the Hospital, Doctors with hospital privileges should 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 which only the anonymous material will be used. 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. 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 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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| (For Hospital Use Only) | <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"/> | | | | | | | |
| <input type="checkbox"/> 15. Maternity | 15. <input type="checkbox"/> | | | | | | | |
| <input type="checkbox"/> 16. Invitro-Fertilisation | 16. <input type="checkbox"/> | | | | | | | |
| <input type="checkbox"/> 17. Radiotherapy | 17. <input type="checkbox"/> | | | | | | | |
| <input type="checkbox"/> 18. Haemodialysis & peritoneal dialysis | 18. <input type="checkbox"/> | | | | | | | |
| <input type="checkbox"/> 19. Focused Ultrasound (for gynaecologists only) | 19. <input type="checkbox"/> | | | | | | | |
| <input type="checkbox"/> 20. Refractive Surgery (LASIK) | 20. <input type="checkbox"/> | | | | | | | |
| Practising Specialty: _____ | | | | | | | | |
| <u>Approved by:</u> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 5px;">Designated member of Hospital Privileges Subcommittee</td> <td style="width: 33%; padding: 5px;">Signature</td> <td style="width: 33%; padding: 5px;">Date</td> </tr> <tr> <td style="height: 30px;"></td> <td></td> <td></td> </tr> </table> | | Designated member of Hospital Privileges Subcommittee | Signature | Date | | | |
| Designated member of Hospital Privileges Subcommittee | Signature | Date | | | | | | |
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