Adventist 港
Health 安
Hong Kong Adventist Hospital
Stubbs Road

# MEDICAL/DENTAL STAFF APPLICATION

Revised
April 2020

**Hong Kong Adventist Hospital – Stubbs Road**
40 Stubbs Road, Hong Kong
Tel. No.: 2835 0581 Fax No.: 2574 6001

## Personal Information Collection Statement

Purpose of Collection

The information provided by you will be used to process your admission privilege application. All information provided will be kept in strict confidence.

Time Period of Retention

Information on unsuccessful or incomplete applicants will be destroyed after 6 months.

Classes of Transferees

Medical Affairs Office may give some of the information to other parties authorized to receive it (such as direct marketing of health services and promotion purpose). We will obtain your consent before using your Personal Data for any other purposes.

Access to Personal Data

You have a right to request access to and correction of your personal data as provided for in sections 18 and 22 and Principle 6 of Schedule 1 of the Personal Data (Privacy) Ordinance. Your right of access includes the right to obtain a copy of your personal data provided in this application form.

Request for personal data access and correction relating to your admission privilege application should be addressed to Medical Affairs Office of Hong Kong Adventist Hospital – Stubbs Road.

Adventist Health 港安
Hong Kong Adventist Hospital
Stubbs Road

## INSTRUCTIONS

1. *This form should be typed if possible.*
2. *Use additional sheets (or the back page) for additional space.*
3. *Attach photocopies of all documents.*

Physician # ____________
*For Office Use Only*

*PLEASE ATTACH RECENT PHOTO HERE*

## IDENTIFYING INFORMATION

Name In Full (both in English & in Chinese, if you have a Chinese name)

| Date of Birth (dd/mm/yyyy) | Place of Birth | Citizenship |
|---|---|---|
| Sex | HKID Number | Marital Status |

Office Address

Home Address

| Office Telephone | Office Fax | Email Address |
|---|---|---|
| Pager | Mobile Phone | Home Telephone |

## PRIVILEGES DESIRED

☐ Dentistry ☐ General Practice

*Specialty:* ____________________
*(Applicant's name must be on the specialist list of the Medical Council of Hong Kong.)*

Procedures perform *(Please tick items applicable):*

| | | |
|---|---|---|
| ☐ Cardiac Catheterization & Intervention | ☐ Endoscopy | ☐ Bronchoscopy |
| ☐ Lithotripsy | ☐ Radiotherapy | ☐ Conscious Sedation |

☐ Others (please specified) ____________________

OT Minor Procedures: (Please List) ____________________

Other: (Please List) ____________________
*(Document training, specialist registration, and experience in CV)*

## MEDICAL/ DENTAL INFORMATION

| PreMedical / PreDental School / College / University | Degree | Date of Graduation |
|---|---|---|
| Medical / Dental School | Degree | Date of Graduation |

***Specialty Training:***

| Hospital | From | To |
|---|---|---|
| Hospital | From | To |
| Hospital | From | To |

*Chronological list of medical / dental activities since internship or residency.*

## PROFESSIONAL REFERENCES

Include **THREE** physicians familiar with your clinical practice with at least one referee must be a physician who is practicing the **same** specialty as you, e.g. Medical Superintendent of Chief of Residency Program. Only one reference can be an associate or a family member.

| Doctor | Contact Address / Fax No. / Email Address |
|---|---|
| Doctor | Contact Address / Fax No. / Email Address |
| Doctor | Contact Address / Fax No. / Email Address |

** Note: If applying for special procedure privileges, please indicate one doctor above for relevant reference, or an additional reference per privilege requested.*

## PREVIOUS PRACTICE(S)

All previous practice(s) in chronological order: Please give full chronological information including last date of practice.

| Address | From | To |
|---|---|---|
| Address | From | To |

## MEMBERSHIP IN PROFESSIONAL SOCIETIES

| Name | Membership Status | Year |
|---|---|---|
| Name | Membership Status | Year |

## FELLOWSHIP ACADEMY OF MEDICINE

| Name | Membership Status | Year |
|---|---|---|
| Name | Membership Status | Year |

## LICENSE TO PRACTISE

Hong Kong Medical Council: ( )

| Hong Kong | License Number (provide photo copy of current license) | Date Issued |
|---|---|---|
| Others | License Number | Date Issued |

## HEALTH STATUS

*If any of the following questions are answered in the affirmative, please provide full explanation on a separate sheet.*

*Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects or likely to affect your ability to perform professional or medical staff duties appropriately?* ☐ Yes ☐ No

Are you currently under care for a continuing health problem? ☐ Yes ☐ No

*Have you at any time during the last five years been hospitalized or received any other type of institutional care for a health problem? If "Yes", please specify below.* ☐ Yes ☐ No

## OTHER INFORMATION

**Please indicate your Insurance Carrier details:**
**I consent for the Hospital to check my medical professional indemnity insurance coverage.**

Insurance Carrier ______________________ Expiration Date ______________

**If the answer to any of the following questions is "Yes", please give Full Details on separate sheet of paper.**

A. *Has your license to practice medicine/dentistry in any jurisdiction ever been limited, suspended or revoked?* ☐ Yes ☐ No

B. *Have you ever been refused membership by any hospital?* ☐ Yes ☐ No

C. *Has your request for any specific clinical privilege ever been denied or granted with stated limitations?* ☐ Yes ☐ No

D. *Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed?* ☐ Yes ☐ No

E. *Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical/dental organization?* ☐ Yes ☐ No

F. *Have you been convicted of any indictable criminal offense?* ☐ Yes ☐ No

G. *Have you been involved with any medical or dental litigation in which an award has been made against you?* ☐ Yes ☐ No

## AGREEMENT STATEMENT

*I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical/dental staff. All information submitted by me in this application is true to my best knowledge and belief.*

*In making this application for appointment to the medical/dental staff of this hospital, I acknowledge that I have received and read the by-laws, rules and regulations of the medical staff of this hospital. I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted. I understand that by not following the rules and regulations, my privileges may be suspended.*

*I understand and agree that I, as an applicant for medical/dental staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.*

## APPLICANT'S SIGNATURE

______________________ ______________
***Signature of Applicant*** ***Date***

***NOTE:***
***A doctor's specimen signature and initial are used by Hospital staff for verification. Please sign with black ball pen.***

Full Signature

Initial Signature

# ADDITIONAL INFORMATION

*For Office Use Only*

**ADMINISTRATIVE APPROVAL**

**Approval Signatures**

| | |
|---|---|
| *Credentials Committee Approval* | *Date* |
| *Medical Staff* | *Date* |
| *Hospital Board* | *Date* |