

Application for Robotic Surgery Privilege

I. Applicant

Name of Applicant: _____ Specialty: _____

Signature of Applicant: _____ Date: _____

II. Application for Types of Robotic Surgery

<input type="checkbox"/> Cardiac Surgery	<input type="checkbox"/> Colorectal Surgery
<input type="checkbox"/> General Surgery	<input type="checkbox"/> Gynecologic Surgery
<input type="checkbox"/> Head & Neck Surgery	<input type="checkbox"/> Thoracic Surgery
<input type="checkbox"/> Urologic Surgery	

III. Experience

Time Period (approximate)	Types of Robotic Procedures	Number of Cases Performed

Kindly provide the log sheet(s) of procedures/surgeries to ascertain competency.

IV. References

(Please provide contact details for **two** referees who perform robotic surgery and currently practicing in the same specialty as you.)

Doctor Contact Address / Fax No. / Email Address

Doctor Contact Address / Fax No. / Email Address

V. Certificate

Please attach copies of relevant certificates.

Number of certificate(s) attached herewith: _____

Please return to Medical Affairs Office, 4C La Rue Building, 40 Stubbs Road, Hong Kong, or by email at medicalaffairs@hkah.org.hk or fax on +(852) 2574 6001.

Thank you for your cooperation.

FOR OFFICE / COMMITTEE MEMBERS USE ONLY

VI. Privilege Status

- Accept
- Decline
- Selective Privilege: _____

Name of Committee: _____

Committee members' signatures: 1. _____ (_____)
2. _____ (_____)

Date of approval: _____