聖保祿醫院
St. Paul's Hospital

CONFIDENTIAL

Practitioner's Code :_____
(For office use only)

Field : _____

Application for Practice of Visiting Allied Health Practitioners

Notes: *(a) Please complete every item **in block letters** and **in black ink in all TWO pages**.*
(b) Please ensure that all information is accurate and complete. If there is insufficient space, please give details on a separate sheet to be attached to this application.
(c) Please send the completed form to "St. Paul's Hospital, 2 Eastern Hospital Road, Causeway Bay, Hong Kong. Attn: MS Office", with all the necessary testimonials/ certificates/ reference letters as specified.
(d) The information collected will solely be used for the purpose of managing your admission privileges and related matters. The collected information will not be disclosed to any other party. Please update your personal data as required.

A. PERSONAL PARTICULARS

1. Full Name in English : _____ Name in Chinese : _____
(Surname) (Other name)

2. HKID Card/Passport No. : _____ 3. Date of Birth : _____

4. Sex/Age : _____ 5. Nationality : _____

6. Address ☐ *Self Employed*
Office : _____
Residence : _____

Photo
(1 passport photo must be attached)

7. Contact
Tel No.(Office) : _____ (Residence) : _____ Mobile : _____ Pager : _____

E-mail : _____ Fax No.(Office) : _____ (Residence) : _____

8. Contact in case of Personal Emergency
Name : _____ Tel No. : _____

9. Business Registration No. (if any) : _____

B. PROFESSIONAL REGISTRATION

I am currently registered with the following Professional Institutes(s) :

Registration No.	Date of Registration	Professional Registration and Institute(s)

** Copies of the certificates must be attached*

Annual Practicing Certificate : (if any) : _____ Date of expiry : _____

C. PROFESSIONAL QUALIFICATION

Date		College attended, Degree granted, Higher qualification *(Copies of certificates should be attached)*
From	To	

** According to chronological orders*

D. CLINICAL TRAINING AND EXPERIENCE

Date		Clinical training and experience after graduation
From	To	

** According to chronological orders*

E. REFEREES

At least 2 names of the referees must be submitted, of whom one must be a visiting doctor of St. Paul's Hospital.
*(The referee must **NOT** be related to the applicant by birth, marriage, de facto or same sex relationship, nor live at the applicant's address)*

	Name of referee	Organization	Telephone / E-mail address
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

F. DECLARATION

In consideration of St. Paul's Hospital ("the Hospital") renewing my application, I undertake to hold the Hospital harmless and indemnify and keep the Hospital indemnified against all loss, damage and liability suffered (including legal fees and expenses incurred) by the Hospital as a result of or in connection with personal injury (including death) and property damage to any person arising out of or in connection with medical treatment, advice or services or acts (personal or otherwise) provided by me to any person in the Hospital, except where the same is solely and exclusively due to any act or neglect of the Hospital.

For the avoidance of doubt, I understand that nothing herein shall create any employer/ employee relationship between the
Hospital and me.

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

I agree to abide by the rules and regulations of the Hospital and cooperate fully. I confirm that the above information

provided is true.

I understand that under normal circumstances, practice privileges have to be renewed every 3 years. I confirm that the above information provided is true. I understand that the Hospital reserves the right to suspend or withdraw privileges granted to me.

APPLICANT
Signature *
Name in Block Letters :
Date (dd/mm/yyyy) :

Please sign within the box in **BLOCK INK*

PLEASE ATTACH COPIES OF (please tick):

- □ 1. Professional Registration Certificate, HK (current)
- □ 2. Annual Practicing Certificate, HK (if any)
- □ 3. CV (updated)
- □ 4. Hong Kong Identity Card
- □ 5. Malpractice Insurance Certificate (Current)
- □ 6. Scope of professional service and fee schedules

FOR OFFICE USE ONLY

THIS APPLICATION IS:

- □ Recommended
- □ Not recommended

ATTACHED DOCUMENT:

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- □ 4. Hong Kong Identity Card
- □ 5. Malpractice Insurance Certificate (Current)
- □ 6. Scope of professional service and fee schedules

VETTING BY	**Name in Block Letters**	**ALLIED HEALTH REPRESENTAIVE**	**Signature :**
	Date (dd/mm/yyyy)		
ENDORSED BY	**Name in Block Letters**	**MEDICAL SUPERINTENDENT**	**Signature :**
	Date (dd/mm/yyyy)		