



Doctor's Code : \_\_\_\_\_  
(For office use only)

## Application for Hospital Privileges

- Notes:
- Please complete the form **in block letters**.
  - Please ensure all information provided is true and correct. If there is insufficient space, please give details on a separate sheet attached to this application.
  - Please send the completed form by post to "St. Paul's Hospital, 2 Eastern Hospital Road, Causeway Bay, Hong Kong. Attn: Chief Medical Executive" with all necessary testimonials/ certificates/ reference letters as specified together with the "Application for New Payment Account Form" and supporting documents as specified.
  - The information collected from you will be used for the purpose of managing your admission privileges and related matters only. You have the right to request access to and correction of information submitted. Please complete and return the "Contact Details Update Form" to us (email: [yvo@stpaul.org.hk](mailto:yvo@stpaul.org.hk); fax: 28375241) or contact the Hospital Management Department.
  - Application processing normally takes 8 – 10 weeks.

### A. PERSONAL PARTICULARS

- Name in English: \_\_\_\_\_ Name in Chinese: \_\_\_\_\_  
(Surname) (Given Name)
- HKID Card No. : \_\_\_\_\_ 3. Date of Birth: \_\_\_\_\_
- Gender: \_\_\_\_\_ 5. Nationality: \_\_\_\_\_
- Marital Status:  Single/ Widowed/ Separated  Married
- Status:  Private Practice  HA (Expected date for private practice: \_\_\_\_\_)  
 University

**Photo**

(1 passport photo must be attached)

- Address (Office): \_\_\_\_\_  
(Residence): \_\_\_\_\_

Correspondence Address:  Office  Residence

- Contact  
Tel No.(Office): \_\_\_\_\_ (Residence): \_\_\_\_\_ Mobile: \_\_\_\_\_ Pager: \_\_\_\_\_  
Fax No.(Office): \_\_\_\_\_ (Residence): \_\_\_\_\_ E-mail: \_\_\_\_\_

### B. PROFESSIONAL REGISTRATION

- I am currently registered with and holding a valid Annual Practising Certificate (APC) of The Medical / Dental Council of Hong Kong.  
\*\*\*Updated practising certificate must be sent to the Hospital **annually** by email ([yvo@stpaul.org.hk](mailto:yvo@stpaul.org.hk)) or by fax (2837 5241).
- General Registration no.: M \_\_\_\_\_ Date of Registration: \_\_\_\_\_
- Specialist Registration in \_\_\_\_\_ (name of specialty);  
Registration no.: S - \_\_\_\_\_ Date of Registration: \_\_\_\_\_
- Medical Protection Society (Medical Professional Indemnity):MPS Code: HK \_\_\_\_\_ Risk level: \_\_\_\_\_  
MPS valid until: \_\_\_\_\_  
\*\*\*Renewed policy showing practising specialty and insured amount must be sent to the Hospital **annually** by email ([yvo@stpaul.org.hk](mailto:yvo@stpaul.org.hk)) or by fax (2837 5241).

### C. QUOTABLE QUALIFICATIONS (Please refer to The Medical/ Dental Council of Hong Kong.)

Year	Qualifications	Year	Qualifications



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### D. CLINICAL EXPERIENCE *(In chronological order. Please use separate sheet, if necessary.)*

Date		Clinical Training and Experience after Graduation
From	To	

### 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.*

	Visiting Physician/ Surgeon of	Contact details of Referee
Name of referee	St. Paul's Hospital	Telephone / E-mail address
1. _____	<input type="checkbox"/> Yes/ <input type="checkbox"/> No	_____
2. _____	<input type="checkbox"/> Yes/ <input type="checkbox"/> No	_____
3. _____	<input type="checkbox"/> Yes/ <input type="checkbox"/> No	_____

### F. HOSPITAL PRIVILEGES APPLIED FOR *(Please tick.)*

PRIVILEGE	SPECIAL CATEGORIES
<input type="checkbox"/> Admission Privilege	
<input type="checkbox"/> Anaesthesiology	<input type="checkbox"/> i Anaesthesiology <input type="checkbox"/> ii Pain Management
<input type="checkbox"/> Cardiovascular Centre	<input type="checkbox"/> i Electrophysiology Study/Radiofrequency Ablation <input type="checkbox"/> ii Transcatheter Pacing/Permanent Pacemaker/Implantable Cardioverter Defibrillator <input type="checkbox"/> iii Micra (Leadless Pacemaker) <input type="checkbox"/> iv Percutaneous Coronary Intervention <input type="checkbox"/> v Left Atrial Appendage Occlusion (LAAO) <input type="checkbox"/> vi Transcatheter Aortic Valve Implantation (TAVI) <input type="checkbox"/> vii Transcatheter Mitral Valve Repair (Mitra Clip) <input type="checkbox"/> viii Renal Denervation (RDN) <input type="checkbox"/> ix Peripheral Vascular Intervention, please specify: _____ <input type="checkbox"/> x Others, please specify: _____
<input type="checkbox"/> Dental Clinic	
<input type="checkbox"/> Electro Diagnostic Centre	<input type="checkbox"/> i Audiogram <input type="checkbox"/> ii Electroencephalography (EEG) <input type="checkbox"/> iii Electromyography (EMG) <input type="checkbox"/> iv Lung Function Test <input type="checkbox"/> v Nerve Conduction Test (NCT) <input type="checkbox"/> vi Non-invasive Cardiac Procedures (including Echocardiography (Echo), Treadmill, Holter, Cardiac Event, Ambulatory Blood Pressure, TEE and Tilt Table Test) <input type="checkbox"/> vii Sleep Study <input type="checkbox"/> viii Others, please specify: _____
<input type="checkbox"/> Endoscopy Centre	<input type="checkbox"/> i Bronchoscopy <input type="checkbox"/> ii Bronchoscopy Endoscopic Ultrasound (EBUS) <input type="checkbox"/> iii Capsule Endoscopy



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		<input type="checkbox"/> iv Colonoscopy <input type="checkbox"/> v Endoscopic Retrograde Cholangiopancreatography (ERCP) <input type="checkbox"/> vi Endoscopic Submucosal Dissection (ESD) <input type="checkbox"/> vii Endoscopic Ultrasound (EUS) <input type="checkbox"/> viii Nasolaryngoscopy/ Micro-laryngoscopy <input type="checkbox"/> ix Oesophageal-Gastro-Duodenoscopy (OGD) <input type="checkbox"/> x Others, please specify: _____
<input type="checkbox"/>	Eye Centre	<input type="checkbox"/> i Argon/YAG/SLT/PDT Laser Machines <input type="checkbox"/> ii Engaged in Laser Refractive Surgery <input type="checkbox"/> Excimer Laser <input type="checkbox"/> Femtosecond Laser <input type="checkbox"/> iii Not engaged in Laser Refractive Surgery <input type="checkbox"/> Excimer Laser <input type="checkbox"/> Femtosecond Laser <input type="checkbox"/> iv OT Facilities
<input type="checkbox"/>	Operating Theatre	<input type="checkbox"/> i Bariatric Surgery <input type="checkbox"/> ii Cardiothoracic Surgery (Including Video-Assisted Thoracoscopy) <input type="checkbox"/> iii Cosmetic / Aesthetic Surgery <input type="checkbox"/> iv General Surgery (Including Laparoscopic Surgery and Varicose Vein Surgery) <input type="checkbox"/> v Gynaecology <input type="checkbox"/> Gynaecological Laparoscopic Surgery, Level: _____ <input type="checkbox"/> vi Neurosurgery <input type="checkbox"/> Spinal Surgery <input type="checkbox"/> vii Obstetrics <input type="checkbox"/> viii Ophthalmology <input type="checkbox"/> ix Oral and Maxillo-Facial Surgery <input type="checkbox"/> x Otorhinolaryngology <input type="checkbox"/> xi Paediatric Surgery <input type="checkbox"/> xii Plastic and Reconstructive Surgery <input type="checkbox"/> xiii Trauma and Orthopaedic Surgery <input type="checkbox"/> Spinal Surgery <input type="checkbox"/> xiv Urology <input type="checkbox"/> xv Vascular Surgery <input type="checkbox"/> xvi Others, please specify: _____
<input type="checkbox"/>	Paediatrics	<input type="checkbox"/> i. Neonatology
<input type="checkbox"/>	Radiology Department	<input type="checkbox"/> i Image-guided Procedures, please specify: _____ <input type="checkbox"/> ii Neurovascular Intervention <input type="checkbox"/> iii Other Endovascular Intervention, please specify: _____ <input type="checkbox"/> iv Others, please specify: _____
<input type="checkbox"/>	Renal Dialysis Centre	
<input type="checkbox"/>	Urology Centre	<input type="checkbox"/> i Lithotripsy <input type="checkbox"/> ii Urodynamic Studies <input type="checkbox"/> iii Cystoscopy <input type="checkbox"/> iv Ureteroscopy <input type="checkbox"/> v Prostate Biopsy
<input type="checkbox"/>	Others	<input type="checkbox"/> i Others, please specify: _____

### G. DECLARATION AND TERMS OF REFERENCE

Have your admission privileges been suspended (wholly or partially) by other private hospitals in Hong Kong or elsewhere?  
 No  Yes (If yes, please state in a separate sheet including the name of the hospital, country, reason, duration and type [temporarily or permanently, admission privilege or facility privilege] of suspension.)

Has your name ever been removed (temporarily or permanently) from the register of medical practitioners of The Medical / Dental Council of Hong Kong or Medical Council elsewhere?  
 No  Yes (If yes, please state clearly in a separate sheet regarding the time, place and reason.)

## Application for 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 St. Paul’s Hospital (SPH). SPH may, at any time, revise these Terms & Conditions without prior notice.

- Doctors should undertake to maintain at all times during his / her practice in SPH, at their own expense, an effective medical indemnity insurance. If at any time s/he ceases to be covered by such valid professional indemnity insurance, s/he will notify SPH immediately.
- Doctors should abide by the “Code of Practice” compiled and approved by the Hong Kong Private Hospitals Association and relevant directives issued by the Department of Health.
- To enhance the quality of care and the delivery of safe practice in SPH, Doctors with hospital privileges must give consent to SPH to select their cases for presentations at our Quality Assurance Meetings, and for the compilation of audit reports. In these circumstances, patients and doctors’ identities will not be revealed.

I understand that under normal circumstances, admission privileges have to be renewed every 3 years. I confirm that the above information provided is true.

I hereby sign and confirm that I am aware of the above terms and conditions of granting of hospital privileges at SPH and that I am physically and mentally fit for the practice of medicine. I have perused this agreement in full before signing it. I understand that SPH reserves the right to suspend or withdraw privileges granted to me at anytime.

Signature *	Initial *
Date (dd/mm/yyyy) :	

PLEASE ATTACH COPIES OF:

1. Hong Kong Identity Card
2. Current Annual Practising Certificate, HK
3. Licence of Registration
3. Specialist Registration Certificate
4. Current Malpractice Insurance Certificate
5. Curriculum Vitae
6. Academic Certificates
7. “Application for New Payment Account” form
  - 7.1 Certificate of Business Registration (if applicable)
  - 7.2 First Page of Bank Account Statement
8. Name Card
9. TWO Referee’s Letters

*\*Note: A doctor’s specimen signature and initials are used by Hospital for verification of prescription order and/or treatment on progress/treatment sheets. . Please sign in black ink.*

### FOR OFFICE USE ONLY

#### APPROVED CATEGORY:

##### Admission Privilege

- Recommended  Not recommended

##### Facility Privilege

- Recommended (Full i.e. all check items)  
 Recommended (Partial i.e. some check items, please specify)

Conditional (Please specify items and conditions)

Not recommended

Remarks:

Signature	Specialist	Chief Medical Executive
Name in Block Letters		
Date (dd/mm/yyyy)		