聖保祿醫院
St. Paul's Hospital

SPHF-HMD-014

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

Application for Additional Hospital Procedure Rights

Notes: (a) *Please complete the form **in block letters**.*
(b) *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.*
(c) *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.*
(d) *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: vmo@stpaul.org.hk; fax: 28375241) or contact the Hospital Management Department.*
(e) *Application processing normally takes 3-4 weeks.*

A. PERSONAL PARTICULARS

1. Name in English: _____ Name in Chinese: _____
(Surname) (Given Name)
2. HKID Card No. : _____ 3. Date of Birth: _____ 4. Gender: _____
5. Nationality: _____ 6. Marital Status: ☐ Single/ Widowed/ Separated ☐ Married
7. Status: ☐ Private Practice ☐ HA (Expected date for private practice: _____) ☐ University
8. Address (Office): _____
(Residence): _____
Correspondence Address: ☐ Office ☐ Residence
9. Contact
Tel No.(Office): _____ (Residence): _____ Mobile: _____ Pager: _____
Fax No.(Office): _____ (Residence): _____ E-mail: _____

B. PROFESSIONAL REGISTRATION

1. 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 (vmo@stpaul.org.hk) or by fax (2837 5241).*
2. Specialist Registration in _____ (name of specialty);
Registration no.: S_____-_____ Date of Registration:_____
3. 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 (vmo@stpaul.org.hk) or by fax (2837 5241).*

C. QUOTABLE QUALIFICATIONS *(In addition to those listed on your previous application of Hospital Privileges submitted to St. Paul's Hospital ONLY)*

Year	Qualifications	Year	Qualifications

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D. ADDITIONAL HOSPITAL PRIVILEGES APPLIED FOR *(Please tick.)*

PRIVILEGE		SPECIAL CATEGORIES	
☐	**Admission Privilege**		
☐	**Anaesthesiology**	☐ i	**Anaesthesiology**
		☐ ii	**Pain Management**
☐	**Cardiovascular Centre**	☐ i	**Electrophysiology Study/Radiofrequency Ablation**
		☐ ii	**Transcatheter Pacing/Permanent Pacemaker/Implantable Cardiovertor Defibrillator**
		☐ iii	**Micra (Leadless Pacemaker)**
		☐ iv	**Percutaneous Coronary Intervention**
		☐ v	**Left Atrial Appendage Occlusion (LAAO)**
		☐ vi	**Transcatheter Aortic Valve Implantation (TAVI)**
		☐ vii	**Transcatheter Mitral Valve Repair (Mitra Clip)**
		☐ viii	**Renal Denervation (RDN)**
		☐ ix	**Peripheral Vascular Intervention, please specify:_____**
		☐ x	**Others, please specify: _____**
☐	**Dental Clinic**		
☐	**Electro Diagnostic Centre**	☐ i	**Audiogram**
		☐ ii	**Electroencephalography (EEG)**
		☐ iii	**Electromyography (EMG)**
		☐ iv	**Lung Function Test**
		☐ v	**Nerve Conduction Test (NCT)**
		☐ vi	**Non-invasive Cardiac Procedures (including Echocardiography (Echo), Treadmill, Holter, Cardiac Event, Ambulatory Blood Pressure, TEE and Tilt Table Test)**
		☐ vii	**Sleep Study**
		☐ viii	**Others, please specify: _____**
☐	**Endoscopy Centre**	☐ i	**Bronchoscopy**
		☐ ii	**Bronchoscopy Endoscopic Ultrasound (EBUS)**
		☐ iii	**Capsule Endoscopy**
		☐ iv	**Colonoscopy**
		☐ v	**Endoscopic Retrograde Cholangiopancreatography (ERCP)**
		☐ vi	**Endoscopic Submucosal Dissection (ESD)**
		☐ vii	**Endoscopic Ultrasound (EUS)**
		☐ viii	**Nasolaryngoscopy/ Micro-laryngoscopy**
		☐ ix	**Oesophageal-Gastro-Duodenoscopy (OGD)**
		☐ x	**Others, please specify: _____**
☐	**Eye Centre**	☐ i	**Argon/YAG/SLT/PDT Laser Machines**
		☐ ii	**Engaged in Laser Refractive Surgery**
			☐ **Excimer Laser**
			☐ **Femtosecond Laser**
		☐ iii	**Not engaged in Laser Refractive Surgery**
			☐ **Excimer Laser**
			☐ **Femtosecond Laser**
		☐ iv	**OT Facilities**
☐	**Oncology Centre**	☐ i.	**Day Chemotherapy**
		☐ ii.	**Radiotherapy**
☐	**Operating Theatre**	☐ i	**Bariatric Surgery**
		☐ ii	**Cardiothoracic Surgery (Including Video-Assisted Thoracoscopy)**
		☐ iii	**Cosmetic / Aesthetic Surgery**
		☐ iv	**General Surgery (Including Laparoscopic Surgery and Varicose Vein Surgery)**
		☐ v	**Gynaecology**
			☐ **Gynaecological Laparoscopic Surgery, Level: _____**
		☐ vi	**Neurosurgery**
			☐ **Spinal Surgery**

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		☐	vii	**Obstetrics**
		☐	viii	**Ophthalmology**
		☐	ix	**Oral and Maxillo-Facial Surgery**
		☐	x	**Otorhinolaryngology**
		☐	xi	**Paediatric Surgery**
		☐	xii	**Plastic and Reconstructive Surgery**
		☐	xiii	**Trauma and Orthopaedic Surgery**
				☐ **Spinal Surgery**
		☐	xiv	**Urology**
		☐	xv	**Vascular Surgery**
		☐	xvi	**Others, please specify:**_____
☐	**Paediatrics**	☐	i.	**Neonatology**
☐	**Radiology Department**	☐	i	**Image-guided Procedures, please specify:**_____
		☐	ii	**Neurovascular Intervention**
		☐	iii	**Other Endovascular Intervention, please specify:** _____
		☐	iv	**Others, please specify:** _____
☐	**Renal Dialysis Centre**			
☐	**Urology Centre**	☐	i	**Lithotripsy**
		☐	ii	**Urodynamic Studies**
		☐	iii	**Cystoscopy**
		☐	iv	**Ureteroscopy**
		☐	v	**Prostate Biopsy**
☐	**Others**	☐	i	**Others, please specify:** _____

E. 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/ Dental Council elsewhere?

☐ *No* ☐ *Yes (If yes, please state clearly in a separate sheet regarding the time, place and reason.)*

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.

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

PLEASE ATTACH COPIES OF:
1. Current Annual Practising Certificate, HK
2. Current Malpractice Insurance Certificate
3. Additional Academic Certificates (if any)
4. Name Card

**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)		