(For Hospital Use Only)

Name of applicant _____ Doctor code_____

寶血醫院（明愛）
Precious Blood Hospital (Caritas)

113 Castle Peak Road, Shamshuipo, Kowloon, Hong Kong
Tel: (852) 3971-9900 Fax : (852) 2728-4290
E-mail : pbh@pbh.hk Website : www.pbh.hk

Application Form for Hospital Privileges

Please attach copies of:

- ❑ 1. Hong Kong Identity Card
- ❑ 2. Curriculum Vitae
- ❑ 3. Certificates of academic and medical qualifications
- ❑ 4. Certificate of Registration (Medical Council of Hong Kong)
- ❑ 5. Specialist Registration Certificate (if applicable)
- ❑ 6. Current Annual Practicing Certificate
- ❑ 7. Current Medical Indemnity Insurance Certificate
- ❑ 8. Two Reference Forms
- ❑ 9. Letter of Authorization for HKMA and MPS
  (Notes: This will be sent to HKMA by Precious Blood Hospital (Caritas) only after your application for hospital privileges is granted)
- ❑ 10. Form for Payment of Professional Fees
- ❑ 11. Form for Application for Car Parking Label (if applicable)
- ❑ 12. Business Card

Notes

1. Please tick only items of Hospital Privileges you will use in our Hospital. For application of privileges for operative procedures please provide supporting evidence of related training and experience.
2. The Hospital reserves the right to grant particular types of privileges.
3. All approved privileges are subject to review by the Hospital.
4. Please provide a copy each of your Annual Practicing Certificate and Medical Indemnity Insurance Certificate to the Hospital every year.
5. Please notify the Hospital of any changes of information.
6. All personal data collected will be treated in strict confidence and be used for application purposes only.

Hospital Privileges applied for: (Please tick only items applicable)

- ☐ 1. Admission of Patients
- ☐ 2. Anaesthesiology
- ☐ 3. OT : Surgical procedures relevant to specialty / training *
- ☐ 4. OT : Minimally invasive surgery relevant to specialty / training *
- ☐ 5. OT : Minor surgical procedures
- ☐ 6. OT : Specified procedures _____
- ☐ 7. Endoscopy : Gastroscopy *
- ☐ 8. Endoscopy : Colonoscopy *
- ☐ 9. Endoscopy : Cystoscopy *
- ☐ 10. Radiology
- ☐ 11. Others (please specify) _____

** Please fill in attached Form A - Application for Operative Procedure Privileges with supporting documents.*

(For Hospital Use Only)

Approved

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____
9. ☐ _____
10. ☐ _____
11. ☐ _____

Approved by:

_____

Designated member of Credentialing Team

Date:

Personal Particulars

Attach recent photo

Name _____
(Block Letters - Surname, Given Name) (in Chinese)

Sex: ☐ F ☐ M Age: _____ Date of Birth : _____
(DD/MM/YY)

HKID Card No: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

Mobile Phone: _____ Pager: _____

E-mail: _____

Personal Emergency Contact Info: Name: _____ Contact No: _____

Please ✓your preference for correspondence address
(Office Address will be chosen as correspondence address by default if not answered)

Office Address ☐ as correspondence address	Telephone	Fax

Residential Address ☐ as correspondence address	Telephone	Fax

Education Information

1. University from which graduated _____

   Year of graduation _____ Degree _____

2. Medical/Dental Council of Hong Kong License No. _____ Date Issued _____

3. Other Quotable Qualifications (with dates) :

Qualifications	Year	Qualifications	Year

Medical / Dental Council of Hong Kong Specialist Registration:

Registered in: _____ (Specialty) Registration No: _____

4. Medical Indemnity Insurance:

   ☐ Medical Protection Society ☐ Others _____ (Name)

   No : _____ Expiry Date: _____ Subscription rate: _____(Risk)

5. Current Appointment: _____

6. Two references: 1. _____ 2. _____

   (Fill in the attached Form B- Reference Request Form, preferably at least one from the same specialty)

Undertaking

- Doctors should maintain their current medical registration with the Hong Kong Medical Council and send a copy of their valid **Annual Practising Certificate** to the Hospital every year.
- Doctors should undertake to maintain at all times during his/her practice in the Hospital, at their own expense, a valid **medical indemnity insurance** policy. The Hospital should be notified at once should the doctor cease to be covered by such valid indemnity insurance.
- Doctors are required to abide by the **"Code of Practice"** approved and promulgated 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 the Hospital, doctors are requested to give consent to the Hospital to select their cases for clinical audit.
- I understand that the **Hospital reserves the right** to suspend or withdraw privileges granted to me.
- I hereby declare that:
  i) I am not found guilty of professional misconduct by any professional body in Hong Kong or elsewhere;
  ii) I am not currently the subject of ongoing disciplinary proceedings in Hong Kong or elsewhere;
  iii) I have not been denied privileges by any other hospital in Hong Kong or elsewhere.
- I confirm that I am **physically and mentally fit** for the practice of medicine and I agree to abide by the Term & Conditions as set out above.

Signature #	**Initial** #

Date: _____

Please sign with black pen

寶血醫院（明愛）
Precious Blood Hospital (Caritas)

Form A

Application for Operative Procedures Privilege

Name of Applicant: _____ Specialty: _____

☐ **A. Surgical Procedures** *(Please provide evidence of training and experience)*

Types of Operative Procedures	No. of Procedures Performed

☐ **B. Endoscopy Procedures** *(Please provide supporting documents, e.g. log book etc.)*

Endoscopy	No. of Procedures Performed
1. Gastroscopy	
2. Colonoscopy	
3. Cystoscopy	

☐ **C. Laparoscopic / Endoscopic Surgery**

☐ General Surgery ☐ Urology ☐ Cardiothoracic ☐ ENT ☐ Ophthalmology
☐ Gynaecology ☐ Neurosurgery ☐ Orthopedic ☐ Others: _____

Experience:

Time Period (approximate)	Types of Laparoscopic/Endoscopic Procedures	No. of Cases Performed

Certificate **:** Please attach relevant copy of certificate (if any). No. of Certificate(s) attached herewith: _____

Name, address & contact number of referees *(one must in the same specialty)*

1. _____

2. _____

Signature of applicant: _____ Date: _____

(For Hospital Use Only)

Privilege Status	Accept	Decline	Selective Privilege
A	☐	☐	☐ _____
B	☐	☐	☐ _____
C	☐	☐	☐ _____

Approved by: _____ Date of Approval: _____

寶血醫院（明愛）
Precious Blood Hospital (Caritas)

Reference Request Form

I am applying for hospital privileges of the Precious Blood Hospital (Caritas). The Hospital requires this reference form to be completed as part of my application process. This constitutes the authority for you to provide information about my character and professional abilities, favorable or otherwise, directly to the Precious Blood Hospital (Caritas) at the above address. All the information provided is kept strictly confidential by the Hospital.

Print/Type Full Name _____ Signature _____ Date _____

THE FOLLOWING SECION TO BE COMPLETED BY INDIVIDUAL REFEREE

1. Employment Record *(To be completed by current / previous employer)*

Name of Employer (HA, other hospitals): _____

(If not employer, please state relationship, e.g. colleague, senior, etc)

Relationship with the applicant: _____

Name of Department (Specialty): _____

Period of Employment: From _____ (mm/yyyy) To _____ (mm/yyyy)

Last Position Held: _____

2. Performance (Please tick the appropriate box)

	Excellent	Good	Average	Below Average
Quality of Work Performance				
Clinical Knowledge				
Personal Integrity				
Ethical Conduct				

Information / assessment is based on:

☐ Personal Knowledge ☐ Personnel Record ☐ Supervisor's Knowledge

☐ Others (Please specify): _____

Additional Comments:

_____

_____

_____

Name of Referee _____ Signature _____

Title _____ Date _____

Chop _____

Please return to Administration Office, Precious Blood Hospital (Caritas), 113 Castle Peak Road, Shamshuipo, Kowloon or by fax at 2728 4290 or by email to gen@pbh.hk

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Quality of Work Performance				
Clinical Knowledge				
Personal Integrity				
Ethical Conduct				

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☐ Personal Knowledge ☐ Personnel Record ☐ Supervisor's Knowledge

☐ Others (Please specify): _____

Additional Comments:

_____

_____

_____

Name of Referee _____ Signature _____

Title _____ Date _____

Chop _____

Please return to Administration Office, Precious Blood Hospital (Caritas), 113 Castle Peak Road, Shamshuipo, Kowloon or by fax at 2728 4290 or by email to gen@pbh.hk

LETTER OF AUTHORIZATION

To: The Hong Kong Medical Association (the HKMA) and The Medical Protection Society Limited (MPS)

1. I, the undersigned, am a current member of MPS.

2. I hereby give consent to the HKMA and MPS to disclose and transfer to the Precious Blood Hospital (Caritas) my information on Membership Grade and MPS Membership Valid Period.

3. The above authorization may be revoked by me by sending an advance notice of not less than 30 days in writing to the HKMA. Any notice so sent shall be addressed to the following address/fax/email of the HKMA:

   [The Hong Kong Medical Association

   5/F Duke of Windsor Social Service Building

   15 Hennessy Road, Wan Chai,

   Hong Kong.

   Fax: 28650943

   Email: mps@hkma.org]

Signature: _____

Name of Signatory: _____

HKID No.: _____

MPS Membership No.: _____

HKMA No.: _____

MCHK No.: _____

Date: _____

寶血醫院（明愛）
Precious Blood Hospital (Caritas)

To : Precious Blood Hospital (Caritas)

Attn : Billing Department

113 Castle Peak Road, Shamshuipo, Kowloon, Hong Kong

Fax : (852) 8148 0902 Tel : (852) 3971 4485

Email : billing@pbh.hk

Doctor Code: _____

Payment of Professional Fees

I agree to accept regular settlement of my doctors' fees through autopay. Details of the payee information as below:

<table>
<tr><td colspan="2">Name of Account Holder</td><td colspan="2"></td></tr>
<tr><td rowspan="2">Bank Information</td><td colspan="3">Bank Name</td></tr>
<tr><td>Bank Code

___ ___ ___</td><td>Branch Number

___ ___ ___</td><td>Account Number

___ ___ ___ ___ ___ ___ ___ ___ ___</td></tr>
<tr><td colspan="4">Business Registration No.:</td></tr>
<tr><td rowspan="2">Additional information</td><td colspan="2">Additional bank account? Please ✓
☐ Yes ☐ No
If yes, please specify effective date:

_____</td><td colspan="2">Set as default account? Please ✓
☐ Yes ☐ No
If yes, please specify effective date:

_____</td></tr>
<tr><td colspan="4">Statement address (For Receiving Doctor Fee Statement):

Unit / Room _____ Floor _____ Block _____

Building Name _____ Street _____

District _____ Kowloon ☐ New Territories ☐ Hong Kong Island ☐</td></tr>
</table>

Please put a "✓ " in the appropriate box and return this form with the following documents:

☐ a Bank statement copy printed with the *registered medical group's name* / *applicant doctor's name and account number*

☐ a Business Registration Certificate copy (for account registered with company name)

_____ _____

Signature Date

_____ _____

Name of doctor (in BLOCK LETTERS) Contact Telephone No.

*We assume you accept any payment methods at the hospital.

PBH(C) will **NOT** be responsible for any dishonoured cheques.

Any card commission involved will be deducted from the professional fees directly.

(Reference commission rate: VISA / MASTER / CUP: 1.6% & EPS / WeChat Pay: 1%, subject for a reasonable adjustment if needed.)

寶血醫院（明愛）
Precious Blood Hospital (Caritas)

Application for Car Parking Label

Personal Information

Name of Doctor: _____ _____
(English in BLOCK LETTERS) (Chinese)

Address: _____

_____

Contact No.: _____

Types of Application (please ✓where applicable)

☐ New Application

Vehicle Reg. No.: (1) _____

(2) _____

☐ Renewal

Vehicle Reg. No.: (1) _____

(2) _____

☐ Change of Vehicle Details

Old Vehicle Reg. No. _____

New Vehicle Reg. No. _____

Terms & Conditions

1. Only one car label is issued to each doctor.
2. Parking label must be displayed in your windscreen.
3. Parking is permitted only when attending to your patients in the Hospital and the doctor is obliged to take his or her car away afterwards.
4. Labels are renewed annually in December.

Doctor's Signature: _____ Date: _____

For Office Use Only

Handled by: _____ Date: _____

Please return the completed form to Administration Office, Precious Blood Hospital (Caritas), 113 Castle Peak Road, Shamshuipo, Kowloon or fax at 2728 4290 or by email to gen@pbh.hk