Gleneagles Hospital
HONG KONG
港怡醫院

Change of Personal Information

Name of Physician: (IN FULL NAME)	**Physician code:** (For office use only)
Email Address:	**Contact Number:**
Other Contact Person/ Number:	

(Please write only the changed items as below)

Res Add: _____ Tel: _____

_____ Fax: _____

Off Add (1): _____ Tel: _____

_____ Fax: _____

Off Add (2): _____ Tel: _____

_____ Fax: _____

Pager: _____ Mobile: _____ Email: _____

Correspondence Address (Please '✓'):

☐ Residential Address ☐ Office Address (1) ☐ Office Address (2)

Preferred telephone contact numbers for clinical emergency:

During usual office hours	Outside office hours
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Effective Date of the above changes: _____

Please return the completed form to:	**Office Use Only:**	
1) Email: ghkma@gleneagles.hk; or 2) Post: 1 Nam Fung Path Wong Chuk Hang (Attn: Medical Affairs Department); or 3) Fax: 3903 3408	Doc. Verified by:	
	Updated by:	
	Reviewed by:	

I hereby certify the above information to be true and correct.

_____ _____

Physician's Signature Date

(**Please use the name signature as your personal record filed in our Hospital**)