Gleneagles Hospital
HONG KONG
港怡醫院

Confidential

Application for Clinical Privileges

- Basic pre-requisite for credentialing of all specialties requires the applicant being holder of a current valid Annual Practicing Certificate, in accordance with the provisions of sub-section (2) of section 20A of the Medical Registration Ordinance; and, listing in the General Register of the Medical Council of Hong Kong under the Medical Registration Ordinance (Cap.161).

- Both the Initial Criteria and Renewal Criteria for clinical privileging are undergoing continuous development. It is envisaged that each Specialty will periodically modify or update the various criteria for their credentialing requirements as deemed appropriate to reflect the experience and competency of the Medical Practitioners that would ensure safety and quality.

- Please attach copies of the following documents with this application:
  - Certificate of Registration with the Medical Council of Hong Kong
  - Specialist Registration Certificate
  - Hong Kong Annual Practicing Certificate
  - Medical Indemnity Insurance Certificate

- Please complete Parts A, B, C & D.

- Please provide supporting evidence of related training and experience in support of the application for clinical privileges.

- Please note that it would normally require 10-12 weeks for processing of the application.

- GHK reserves the right to grant particular types of privileges, and all approved privileges are subject to review by GHK.

- Please notify GHK on any changes of the information provided.

- The personal data collected in this application form will only be used by Gleneagles Hospital Hong Kong (GHK) for credentialing. Under the Personal Data (Privacy) Ordinance, you have a right to request access to, and to request correction of, your personal data in relation to your application. If you wish to exercise these rights, please contact GHK Office at Tel: (852) 3153 9388 or Email: credentialing@gleneagles.hk.

PART A
Personal Information

<table>
<tr><td colspan="7">1. Applicant's Personal Particulars</td></tr>
<tr><td>Applicant's Name*</td><td colspan="5"></td><td rowspan="4">Photo</td></tr>
<tr><td>Name in Chinese*</td><td colspan="5"></td></tr>
<tr><td>HKID*</td><td colspan="5"></td></tr>
<tr><td>Passport No.
(Please provide details if you do not possess a HKID card)</td><td colspan="5"></td></tr>
<tr><td>Country of Issue</td><td colspan="4"></td><td>Expiry Date</td><td></td></tr>
<tr><td>Nationality^</td><td colspan="6"></td></tr>
<tr><td>Date of Birth</td><td>DD</td><td colspan="2">MM</td><td colspan="3">YYYY</td></tr>
<tr><td>Gender*</td><td colspan="3">☐ Female</td><td colspan="3">☐Male</td></tr>
<tr><td>Marital Status^</td><td>☐Single</td><td colspan="2">☐Married</td><td colspan="3">☐Divorced</td></tr>
<tr><td>Mobile Phone No.*</td><td colspan="2"></td><td colspan="2">Home No.^</td><td colspan="2"></td></tr>
<tr><td>Pager No.</td><td colspan="6"></td></tr>
<tr><td>Email Address</td><td colspan="6"></td></tr>
<tr><td>Priority Call Telephone No.*</td><td colspan="6">Please rank the following on a scale of “1” (first priority) to “4”
Mobile No.:____Pager No.:_____Office No.:_____Home No.:______</td></tr>
<tr><td rowspan="3">Emergency Contact Person(s)</td><td colspan="3">(1) <u>Clinical</u>
Name:</td><td colspan="3">Contact No.:</td></tr>
<tr><td colspan="6">(2) <u>Personal</u>
Name:</td></tr>
<tr><td colspan="3">Relationship:</td><td colspan="3">Contact No.:</td></tr>
<tr><td rowspan="2">Business Address</td><td colspan="6"></td></tr>
<tr><td colspan="3">Contact No.:</td><td colspan="3">Fax No.:</td></tr>
<tr><td>Residential Address</td><td colspan="6"></td></tr>
<tr><td>Correspondence Address
(if different from the above address)</td><td colspan="6"></td></tr>
<tr><td>Current Appointment(s)^
(any paid/unpaid appointment(s)to universities, public organizations or private organizations)</td><td colspan="6"></td></tr>
</table>

Please ☑ as appropriate
***Mandatory*, ^Optional**

2. Academic Background

University Attended		
Degree Obtained		
Year of Graduation		
First registration with Medical Council of Hong Kong	Date (year) :	
	Registration no.:	
	Qualification used:	
Other Quotable Qualifications^	Date (year) :	Qualification:
	Date (year) :	Qualification:
	Date (year) :	Qualification:
	Date (year) :	Qualification:
	Date (year) :	Qualification:
Medical Council of Hong Kong Specialist Registration	Registered in (specialty):	
	Specialist Registration No.:	
Fellowship of Hong Kong Academy of Medicine (specialty)		
Other Specialist Qualifications^		

Medical Indemnity Insurance	MPS No.: or										
	Other No.:										
	Expiry Date:										
MPS subscription rate information* (please refer to the explanatory notes below)	Risk:		HGI		HGM		HKS		HKC		MOB
			COS		INN		SHS		VHR		MHR
			INA		MMR		MLR		PGM		PGZ
			PGP		PGO		XGP		NSM		PHY
			DTC		OCU	others:					

***Please ☑ as appropriate**
^Optional

Explanatory Notes	
Government and Hospital Authority Rates	- HGI: Intern; - HGM:Medical Officer/Medical Officer Trainee/AssistantProfessor; - HKS: Senior Medical Officer/Specialist/Associate Professor; - HKC: Consultant/Professor/Director
Private Hospital Rates	- MOB: Obstetrics; - COS: Cosmetic/aesthetic practice; - INN: Neurosurgery; - SHS: Super High Risk; - VHR: Very High Risk; - MHR: High Risk; - INA: Anaesthetics; - MMR: Medium Risk; - MLR: Low Risk; - PGM: GP Non Procedural– consultative office procedures and assisting; - PGZ: GP Non Procedural– consultative office procedures and assisting; - PGP: GP Procedural; - PGO: GP Risk with obstetrics; - XGP: Cosmetic and Aesthetic Medicine; - NSM: Non-clinical: advisory services only - PHY: Physiotherapist; - DTC: Dietician; - OCU: Occupational Therapist

3. Referees

Please provide details of three referees including their names, correspondence addresses, faxes/e-mail addresses and indicate their relationship(s) with you after you have obtained their consent. The referees should not be immediate family members or spouse; and should be someone who would be able to comment on your professional attributes.

Name	
Position	
Correspondence Address	
Telephone Number	
E-mail Address/ Fax No.	
Relationship with Applicant	

Name	
Position	
Correspondence Address	
Telephone Number	
E-mail Address/ Fax No.	
Relationship with Applicant	

Name	
Position	
Correspondence Address	
Telephone Number	
E-mail Address/ Fax No.	
Relationship with Applicant	

Unless otherwise specified, consent is deemed given by the applicant to the Hospital to approach the above referees whenever appropriate without prior notification. Please also inform your referees that such consent has been given by you.

PART B
Professional Information

1. WORK EXPERIENCE (in descending chronological order)

Dates (month/year)		Name of Employment Institution	Position Held and Specialty (if part-time please state this clearly)
From	To		

2. PROFESSIONAL SERVICES (OPTIONAL)

Dates & Places	Name/ Type of Service programme (guidelines) / Clinic/ Skills **Example:** HA Professional bodies (Colleges, Medical Councils, Professional Associations) Private Hospital	Role of Involvement **Example:** As Council Member As Chairman As President As Board Member

3. EXPERIENCE AS TEACHER / TRAINER (OPTIONAL)

Dates/ Periods	Name of Professional Body **Example:** The University of Hong Kong or The Chinese University of Hong Kong or Hospital Authority hospital	Educational Activities **Example:** Undergraduate Medical and Nursingstudents (for HKU, CUHK, PolyU or others) Providing specialty training for Collegesof Hong Kong Academy of Medicine	Participation **Example:** In capacity as honorary teacher: Honorary Associate Professor/ Clinical Teaching In capacity of trainer

4. CURRENT AND PAST ADMISSION RIGHTS AND PRIVILEGES GRANTED BY OTHER PRIVATE HOSPITALS*

Hospitals in Hong Kong	Current	Past	Reason for cessation if no longer current
Canossa Hospital	☐	☐	
CUHK Medical Centre	☐	☐	
Evangel Hospital	☐	☐	
Hong Kong Adventist Hospital - Stubbs Road	☐	☐	
Hong Kong Adventist Hospital - Tsuen Wan	☐	☐	
Hong Kong Baptist Hospital	☐	☐	
Hong Kong Sanatorium & Hospital	☐	☐	
Matilda International Hospital	☐	☐	
Precious Blood Hospital	☐	☐	
St. Paul's Hospital	☐	☐	
St Teresa's Hospital	☐	☐	
Union Hospital	☐	☐	
Non-local Hospitals	**Current**	**Past**	**Reason for cessation if no longer current**

Have you ever had your clinical privileges being refused, evoked or restricted in any way by any hospital(s)? Yes / No^. If Yes, please give details :

***Please ☑ as appropriate**

^Please delete as appropriate

PART C

Request for Privileges – Respiratory Medicine

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY ☑ the privileges you apply for)		
Core Privileges in Respiratory Medicine		
☐	Admit, evaluate, diagnose, consult, perform history and physical exam, and provide treatment to patients presenting with conditions, disorders, injuries, and disease of the organs of the thorax or chest, airways and lungs, mediastinal contents, diaphragm, and pulmonary circulatory system	Registered in the Specialist Register on Respiratory Medicine (S22) in the Specialist Register of the Medical Council of Hong Kong OR Registered in the Specialist Register of the Medical Council of Hong Kong in another Specialty and Fellow of the Hong Kong Academy of Medicine with accreditation in Respiratory Medicine AND Documented experience in managing in-patients and out-patients with respiratory problems in public or private healthcare systems for at least 5 years AND In active practice
Special Privileges in Respiratory Medicine (must meet the criteria of Core Privileges as stated above)		
☐	Management of Non-invasive ventilation	Evidence of post-specialist accreditation experience (in-patient) in Respiratory Medicine for at least 5 years AND Total experience of at least 100 cases managed AND In active practice

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY ☑ the privileges you apply for)		
☐	Management of Invasive mechanical ventilation	Evidence of post-specialist accreditation experience (in-patient) in Respiratory Medicine for at least 5 years AND Total experience of at least 100 cases managed AND In active practice
☐	Endotracheal Intubation (Elective)	Evidence of post-specialist accreditation experience (in-patient) in Respiratory Medicine for at least 5 years AND Total experience of at least 100 cases performed AND In active practice
☐	Pleurocentesis	Evidence of post-specialist accreditation experience (in-patient) in Respiratory Medicine for at least 5 years AND Total experience of at least 50 procedures performed AND In active practice

<table>
<tr><th>REQUESTED</th><th>PROCEDURE</th><th>INITIAL CRITERIA</th></tr>
<tr><td colspan="3">(Please ONLY ☑ the privileges you apply for)</td></tr>
<tr><td>☐</td><td>Ultrasound pleura</td><td>Must have received training in ultrasound pleura (certification or reference letter must be provided)

AND

Total experience of at least 50 procedures managed and in active practice

AND

In active practice</td></tr>
<tr><td>☐</td><td>Insertion of chest drain (tube thoracostomy)</td><td rowspan="2">Evidence of post-specialist accreditation experience (in-patient) in Respiratory Medicine for at least 5 years

AND

Total experience of at least 50 procedures performed

AND

In active practice</td></tr>
<tr><td>☐</td><td>Tube Thoracostomy Under Ultrasound guidance</td></tr>
</table>

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY ☑ the privileges you apply for)		
☐	Pleurodesis	Must have fulfilled requirement of Chest drain insertion (see above) AND Total experience of at least 30 procedures performed AND In active practice
☐	Insertion and management of Indwelling Tunneled Pleural Catheter	Must have fulfilled requirement for Chest Drain Insertion (see above) AND Evidence of training in insertion of tunneled pleural catheter AND Total experience of at least 30 procedures performed AND In active practice

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY ☑ the privileges you apply for)		
☐	Flexible Pleuroscopy	Must have fulfilled requirement for Chest Drain Insertion (see above) AND Have received training in Flexible Pleuroscopy AND Total experience of at least 10 procedures as chief operator AND In active practice
☐	Flexible bronchoscopy OR Flexible bronchoscopy and endobronchial biopsy	Evidence of post-specialist accreditation experience (in-patient) in Respiratory Medicine for at least 5 years AND Total experience of 100 bronchoscopy procedures with minimum of 20 endobronchial biopsies AND In active practice
☐	Flexible bronchoscopy and transbronchial biopsy with or without fluoroscopic guidance	Evidence of post-specialist accreditation experience (in-patient) in Respiratory Medicine for at least 5 years AND Total experience of 100 bronchoscopy procedures with minimum of 20 transbronchial biopsies (with or without fluroscopic guidance respectively) AND In active practice

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY ☑ the privileges you apply for)		
☐	Endobronchial ultrasound (EBUS) and transbronchial needle biopsy	Must have fulfilled requirement for flexible bronchoscopy (see above) AND Total experience of 40 EBUS with transbronchial needle biopsy procedures performed as lead operator AND In active practice
☐	Flexible bronchoscopy with autoflurescent imaging (AFI)	Must have fulfilled requirement for flexible bronchoscopy (see above) AND Total experience of at least 40 procedures with minimum of 20 biopsies AND In active practice
☐	Polysomnogram Studies Interpretation and Reporting	Total experience of at least 100 in-laboratory overnight AASM-compliant polysomnographic studies interpreted AND In active practice
☐	TPN Management	In active practice

<table>
<tr><td>REQUESTED</td><td>PROCEDURE</td><td>INITIAL CRITERIA</td></tr>
<tr><td colspan="3">(Please ONLY ☑ the privileges you apply for)</td></tr>
<tr><td>☐</td><td>Arterial Catheter insertion and management</td><td rowspan="2">Total experience of at least 50 procedures managed
AND
In active practice (>10 times in past 3 years)</td></tr>
<tr><td>☐</td><td>Paracentesis</td></tr>
<tr><td>☐</td><td>Central Venous Lines Insertion</td><td rowspan="2">Total experience of at least 50 procedures managed
AND
In active practice (>10 times in past 3 years)</td></tr>
<tr><td>☐</td><td>Central Venous Catheters insertion under ultrasound guidance</td></tr>
</table>

PART D

Request for Sedation Privileges

Self-Declaration

Are you seeking for sedation privileges at GHK? ☐ Yes* ☐ No

*If "Yes", applicant has to be fully conversant with the sedation policy of GHK.

I hereby confirm that I have read and fully understood the policy.

____

Self-Declaration Signature

ACKNOWLEDGMENTS OF THE PRACTITIONER:

I have hereby requested only those privileges for which, by education, training, experience and demonstrated past performance, I am qualified to perform, and that I wish to exercise at the Gleneagles Hospital Hong Kong. I also acknowledge that my professional malpractice and indemnity insurance extends to all privileges that I have requested.

I understand that in exercising any clinical privileges granted, I will abide by hospital and medical staff policies and rules.

Applicant signature : _______________ **Date :** _______________

Applicant Name : _______________