

## **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](mailto:credentialing@gleneagles.hk).

**PART A**  
**Personal Information**

| <b>1. Applicant's Personal Particulars</b>  |   |                                  |                                   |
|---|---|----------------------------------|-----------------------------------|
| Applicant's Name*   |   |                                  | Photo                             |
| Name in Chinese*  |   |                                  |                                   |
| HKID*   |   |                                  |                                   |
| Passport No.<br><small>(Please provide details if you do not possess a HKID card)</small>   |   |                                  |                                   |
| Country of Issue  |   | Expiry<br>Date                   |                                   |
| Nationality^  |   |                                  |                                   |
| Date of Birth   | DD  | MM                               | YYYY                              |
| Gender*   | <input type="checkbox"/> Female   |                                  | <input type="checkbox"/> Male     |
| Marital Status^   | <input type="checkbox"/> Single   | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| Mobile Phone No.*   |   | Home No.^                        |                                   |
| Pager No.   |   |                                  |                                   |
| Email Address   |   |                                  |                                   |
| Priority Call Telephone No.*  | Please rank the following on a scale of "1" (first priority) to "4"<br>Mobile No.:____ Pager No.:____ Office No.:____ Home No.:____ |                                  |                                   |
| Emergency Contact Person(s)   | (1) <u>Clinical</u><br>Name:  |                                  | Contact No.:                      |
|   | (2) <u>Personal</u><br>Name:  |                                  |                                   |
|   | Relationship:   |                                  | Contact No.:                      |
| Business Address  |   |                                  |                                   |
|   | Contact No.:  |                                  | Fax No.:                          |
| Residential Address   |   |                                  |                                   |
| Correspondence Address<br><small>(if different from the above address)</small>  |   |                                  |                                   |
| Current Appointment(s)^<br><small>(any paid/unpaid appointment(s) to universities, public organizations or private organizations)</small> |   |                                  |                                   |

Please  as appropriate  
\*Mandatory, ^Optional

| <b>2. Academic Background</b>                           |                                   |
|---|-----------------------------------|
| 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*<br>(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 | <ul style="list-style-type: none"> <li>- HGI: Intern;</li> <li>- HGM: Medical Officer/Medical Officer Trainee/Assistant Professor;</li> <li>- HKS: Senior Medical Officer/Specialist/Associate Professor;</li> <li>- HKC: Consultant/Professor/Director</li> </ul>  |
| Private Hospital Rates                  | <ul style="list-style-type: none"> <li>- MOB: Obstetrics;</li> <li>- COS: Cosmetic/aesthetic practice;</li> <li>- INN: Neurosurgery;</li> <li>- SHS: Super High Risk;</li> <li>- VHR: Very High Risk;</li> <li>- MHR: High Risk;</li> <li>- INA: Anaesthetics;</li> <li>- MMR: Medium Risk;</li> <li>- MLR: Low Risk;</li> <li>- PGM: GP Non Procedural– consultative office procedures and assisting;</li> <li>- PGZ: GP Non Procedural– consultative office procedures and assisting;</li> <li>- PGP: GP Procedural;</li> <li>- PGO: GP Risk with obstetrics;</li> <li>- XGP: Cosmetic and Aesthetic Medicine;</li> <li>- NSM: Non-clinical: advisory services only</li> <li>- PHY: Physiotherapist;</li> <li>- DTC: Dietician;</li> <li>- OCU: Occupational Therapist</li> </ul> |

### 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)**

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

**2. PROFESSIONAL SERVICES (OPTIONAL)**

| <b>Dates &amp; Places</b> | <b>Name/ Type of Service programme (guidelines) / Clinic/ Skills</b><br><br><b>Example:</b><br>HA<br>Professional bodies (Colleges, Medical Councils, Professional Associations)<br>Private Hospital | <b>Role of Involvement</b><br><br><b>Example:</b><br>As Council Member<br>As Chairman<br>As President<br>As Board Member |
|---------------------------|--|--|
|                           |  |  |

**3. EXPERIENCE AS TEACHER / TRAINER (OPTIONAL)**

| <b>Dates/ Periods</b> | <b>Name of Professional Body</b><br><br><b>Example:</b><br>The University of Hong Kong<br>or<br>The Chinese University of Hong Kong<br>or<br>Hospital Authority hospital | <b>Educational Activities</b><br><br><b>Example:</b><br>Undergraduate Medical and Nursing students (for HKU, CUHK, PolyU or others)<br><br>Providing specialty training for Colleges of Hong Kong Academy of Medicine | <b>Participation</b><br><br><b>Example:</b><br>In capacity as honorary teacher: Honorary Associate Professor/ Clinical Teaching<br><br>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   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| CUHK Medical Centre  | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Evangel Hospital   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Hong Kong Adventist Hospital - Stubbs Road   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Hong Kong Adventist Hospital - Tsuen Wan   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Hong Kong Baptist Hospital   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Hong Kong Sanatorium & Hospital  | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Matilda International Hospital   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Precious Blood Hospital  | <input type="checkbox"/> | <input type="checkbox"/> |   |
| St. Paul's Hospital  | <input type="checkbox"/> | <input type="checkbox"/> |   |
| St Teresa's Hospital   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Union Hospital   | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Non-local Hospitals  | Current                  | Past                     | Reason for cessation if no longer current |
|  |                          |                          |   |
| <p>Have you ever had your clinical privileges being refused, evoked or restricted in any way by any hospital(s)?    Yes /    No<sup>^</sup>. If Yes, please give details :</p> |                          |                          |   |
|  |                          |                          |   |

\*Please  as appropriate

<sup>^</sup>Please delete as appropriate



## PART C

### Request for Privileges – Nuclear Medicine

| REQUESTED   | PROCEDURE                            | INITIAL CRITERIA   |
|---|--------------------------------------|--|
| <b>(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)</b> |                                      |  |
| <b>Core Privileges in Nuclear Medicine</b>  |                                      |  |
| <input type="checkbox"/>  | Apply for <b>ALL</b> core privileges |  |
| <input type="checkbox"/>  | Cardiovascular & Pulmonary           | Registered in the Specialist Register in Nuclear Medicine (27) of the Medical Council of Hong Kong<br><br>OR<br><br>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 Nuclear Medicine<br><br>AND<br><br>Total experience of at least 60 cases<br><br>AND<br><br>In active practice |
| <input type="checkbox"/>  | Endocrinology                        | Registered in the Specialist Register in Nuclear Medicine (27) of the Medical Council of Hong Kong<br><br>OR<br><br>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 Nuclear Medicine<br><br>AND<br><br>Total experience of at least 50 cases<br><br>AND<br><br>In active practice |

| REQUESTED   | PROCEDURE                    | INITIAL CRITERIA   |
|---|------------------------------|--|
| <b>(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)</b> |                              |  |
| <input type="checkbox"/>  | Neurology GI & Hepatobiliary | Registered in the Specialist Register in Nuclear Medicine (27) of the Medical Council of Hong Kong<br><br>OR<br><br>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 Nuclear Medicine<br><br>AND<br><br>Total experience of at least 20 cases<br><br>AND<br><br>In active practice |
| <input type="checkbox"/>  | Nephrology & Urology         | Registered in the Specialist Register in Nuclear Medicine (27) of the Medical Council of Hong Kong<br><br>OR<br><br>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 Nuclear Medicine<br><br>AND<br><br>Total experience of at least 60 cases<br><br>AND<br><br>In active practice |

| REQUESTED   | PROCEDURE                        | INITIAL CRITERIA  |
|---|----------------------------------|---|
| <b>(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)</b> |                                  |   |
| <input type="checkbox"/>  | Haematology Infection & Oncology | Registered in the Specialist Register in Nuclear Medicine (27) of the Medical Council of Hong Kong<br><br>OR<br><br>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 Nuclear Medicine<br><br>AND<br><br>Total experience of at least 20 cases<br><br>AND<br><br>In active practice  |
| <input type="checkbox"/>  | Skeletal                         | Registered in the Specialist Register in Nuclear Medicine (27) of the Medical Council of Hong Kong<br><br>OR<br><br>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 Nuclear Medicine<br><br>AND<br><br>Total experience of at least 100 cases<br><br>AND<br><br>In active practice |

| REQUESTED   | PROCEDURE | INITIAL CRITERIA   |
|---|-----------|--|
| <b>(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)</b> |           |  |
| <input type="checkbox"/>  | PET/CT    | <p>Registered in the Specialist Register in Nuclear Medicine (27) of the Medical Council of Hong Kong</p> <p>OR</p> <p>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 Nuclear Medicine</p> <p>AND</p> <p>Total experience of at least 250 cases</p> <p>AND</p> <p>In active practice</p> |

## 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.

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**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 :** \_\_\_\_\_