

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

1. Applicant's Personal Particulars			
Applicant's Name*			Photo
Name in Chinese*			
HKID*			
Passport No. <small>(Please provide details if you do not possess a HKID card)</small>			
Country of Issue		Expiry 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" Mobile No.: ____ Pager No.: ____ Office No.: ____ Home No.: ____		
Emergency Contact Person(s)	(1) <u>Clinical</u> Name:		Contact No.:
	(2) <u>Personal</u> Name:		
	Relationship:		Contact No.:
Business Address			
	Contact No.:		Fax No.:
Residential Address			
Correspondence Address <small>(if different from the above address)</small>			
Current Appointment(s)^ <small>(any paid/unpaid appointment(s) to universities, public organizations or private organizations)</small>			

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:	<input type="checkbox"/> HGI	<input type="checkbox"/> HGM	<input type="checkbox"/> HKS	<input type="checkbox"/> HKC	<input type="checkbox"/> MOB
		<input type="checkbox"/> COS	<input type="checkbox"/> INN	<input type="checkbox"/> SHS	<input type="checkbox"/> VHR	<input type="checkbox"/> MHR
		<input type="checkbox"/> INA	<input type="checkbox"/> MMR	<input type="checkbox"/> MLR	<input type="checkbox"/> PGM	<input type="checkbox"/> PGZ
		<input type="checkbox"/> PGP	<input type="checkbox"/> PGO	<input type="checkbox"/> XGP	<input type="checkbox"/> NSM	<input type="checkbox"/> PHY
		<input type="checkbox"/> DTC	<input type="checkbox"/> OCU	<input type="checkbox"/> others:		

*Please as appropriate
^Optional

Explanatory Notes	
Government and Hospital Authority Rates	<ul style="list-style-type: none"> - HGI: Intern; - HGM: Medical Officer/Medical Officer Trainee/Assistant Professor; - HKS: Senior Medical Officer/Specialist/Associate Professor; - HKC: Consultant/Professor/Director
Private Hospital Rates	<ul style="list-style-type: none"> - 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 Nursing students (for HKU, CUHK, PolyU or others) Providing specialty training for Colleges of 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	<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[^]. If Yes, please give details :</p>			

*Please as appropriate

[^]Please delete as appropriate

PART C

Request for Privileges – Cardio-thoracic Surgery

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)		
Core Privileges in Cardio-thoracic Surgery		
<input type="checkbox"/>	Apply for ALL core privileges	
<input type="checkbox"/>	Insertion/removal of intra aortic balloon	Registered in the Specialist Register in Cardio-thoracic Surgery (S31) 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 Cardio-thoracic Surgery AND In active practice
<input type="checkbox"/>	Excision / Creation of Arterio-Venour Fistula	
<input type="checkbox"/>	Arterial Embolectomy	
<input type="checkbox"/>	Coronary artery bypass graft	
<input type="checkbox"/>	Heart block, insertion/replacement of pacemaker (permanent)	
<input type="checkbox"/>	Pericardial disease, pericardiectomy	
<input type="checkbox"/>	Pericardial effusion, paracentesis/ transthoracic drainage	
<input type="checkbox"/>	Cardiac biopsy	
<input type="checkbox"/>	Aortic aneurysm, excision and insertion of graft	
<input type="checkbox"/>	Proximal aortic aneurysm, aortic root replacement with coronary artery re-implantation	
<input type="checkbox"/>	Pneumonectomy/lobectomy/segmental resection	
<input type="checkbox"/>	Resection of rib and open exploration / Drainage of thoracic cavity	
<input type="checkbox"/>	Pectus excavatum/ pectus carnatum, radical correction	
<input type="checkbox"/>	Mediastinal tumour resection	
<input type="checkbox"/>	Chest wall resection and reconstruction	
<input type="checkbox"/>	Foreign body, removal	
<input type="checkbox"/>	Tracheostomy	
<input type="checkbox"/>	Arterio-venous fistula, dissection and ligation	

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)		
<input type="checkbox"/>	Arteriovenous shunt surgery	Registered in the Specialist Register in Cardio-thoracic Surgery (S31) 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 Cardio-thoracic Surgery AND In active practice
<input type="checkbox"/>	Saphenous to femoral cross-leg bypass graft	
<input type="checkbox"/>	Pleurodesis	
<input type="checkbox"/>	Temporary Pace Wire Insertion	
<input type="checkbox"/>	Bronchoscopy	
<input type="checkbox"/>	Thoracoscopy & Video assisted thoracic surgery (TVATS)	
<input type="checkbox"/>	Valve Repair / Valve Replacement / Valve Surgery	
<input type="checkbox"/>	Ventilator Management	
<input type="checkbox"/>	Endotracheal Intubation	
<input type="checkbox"/>	Arterial Catheter Insertion and Management	
<input type="checkbox"/>	TPN Management	
<input type="checkbox"/>	Central Venous Lines Insertion	
<input type="checkbox"/>	Tube Thoracostomy	
<input type="checkbox"/>	Pleurocentesis	
<input type="checkbox"/>	Fibreoptic bronchoscopy and bronchoalveolar lavage	

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)		
Special Privileges in Cardio-thoracic Surgery (must meet the criteria of Core Privileges as stated above)		
<input type="checkbox"/>	Congenital heart disease - open heart surgery	<p>Recommendation from supervisor or peer on advanced standing</p> <p>AND</p> <p>In active practice</p>
<input type="checkbox"/>	Congenital heart disease (complex) - open heart surgery	
<input type="checkbox"/>	Patent ductus arteriosus, ligation	
<input type="checkbox"/>	Pulmonary incompetence, pulmonary artery banding	
<input type="checkbox"/>	Surgical procedures for the correction of arrhythmia	
<input type="checkbox"/>	Heart / Lung transplant surgery	
<input type="checkbox"/>	Heart transplant surgery	
<input type="checkbox"/>	Robotic Cardiac Surgery	

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)		
<input type="checkbox"/>	Robotic Thoracic Surgery	<p>5 years post fellowship or equivalent qualification for specialist training in cardio-thoracic surgery (including specialty) and able to demonstrate that he/she is actively working as a full time in cardio-thoracic surgery (subspecialty) in his/her practice in the past 3 years and has adequate experience in specific individual procedures</p> <p>AND</p> <p>A certificate in robotic surgery as console surgeon</p> <p>AND</p> <p>Total experience of at least 10 cases</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.

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 : _____