

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 – Vascular Surgery

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)		
Core Privileges in Vascular Surgery		
<input type="checkbox"/>	Apply for ALL core privileges	
<input type="checkbox"/>	Varicose vein operations confining to ligation and stripping and injection sclerotherapy	<p>Registered in the Specialist Register in General Surgery (S28) or Vascular Surgery (S64) of the Medical Council of Hong Kong</p> <p>AND</p> <p>At least 3 years full time hospital appointment in general surgery or vascular surgery post fellowship or equivalent qualification, and able to demonstrate that he/she is actively working in these 2 specialties in his/her practice in the past 3 years.</p>
<input type="checkbox"/>	Arterial Catheter Insertion and Management	
<input type="checkbox"/>	Arterial Surgery: Extremities <ul style="list-style-type: none"> - Infra-inguinal arterial bypasses: Femoro-popliteal - Extra-anatomical bypasses: Femoro-femoral and axillo-femoral bypasses - Femoro/popliteal endarterectomy, thrombectomy and embolectomy - Upper limb artery embolectomy / thrombectomy 	
<input type="checkbox"/>	Endovascular Surgery: Extremities <ul style="list-style-type: none"> - Angioplasty and stenting of lower limb arteries 	
<input type="checkbox"/>	Vascular Access / Dialysis Procedures <ul style="list-style-type: none"> - AV fistula creation / revision - AV Grafts for dialysis Central venous catheter insertion 	
<input type="checkbox"/>	Limb Amputation	

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)		
Special Privileges in Vascular Surgery (must meet the criteria of Core Privileges as stated above)		
<input type="checkbox"/>	<u>Vascular Surgery</u> Arterial Surgery: Extremities - femoro-distal bypasses	5 years post fellowship or equivalent qualification for specialist training in general surgery or vascular surgery and be able to demonstrate that he/she has adequate experience in specific individual procedures
<input type="checkbox"/>	<u>Vascular Surgery</u> Arterial Surgery: Abdominal Aorta (Simple) - Open repair of infrarenal aortic aneurysms / iliac aneurysms - Aorto-ililac / aorto-femoral bypasses	
<input type="checkbox"/>	<u>Vascular Surgery</u> Arterial Surgery: Abdominal Aorta and Visceral (Complex) - Open repair of juxtarenal / pararenal aorta with reconstruction - Visceral (Celiac, SMA, renal artery) artery bypasses and reconstruction	
<input type="checkbox"/>	<u>Vascular Surgery</u> Arterial Surgery: Thoracic/Thoraco-Abdominal - Open repair of thoraco-abdominal aorta with reconstruction	
<input type="checkbox"/>	<u>Vascular Surgery</u> Arterial Surgery: Cerebrovascular - Carotid endarterectomy Extracranial carotid / subclavian bypasses	
<input type="checkbox"/>	<u>Vascular Surgery</u> Endovascular Surgery: Extremities - Angioplasty and stenting of upper limb arteries - Intra-arterial thrombolysis - Lower limb atherectomy	

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)		
<input type="checkbox"/>	<u>Vascular Surgery</u> Endovascular Surgery: Abdominal Aorta <ul style="list-style-type: none"> - Endovascular repair of infrarenal abdominal aortic aneurysms - Endovascular repair of iliac aneurysms - Embolization of iliac arteries 	5 years post fellowship or equivalent qualification for specialist training in general surgery or vascular surgery and be able to demonstrate that he/she has adequate experience in specific individual procedures
<input type="checkbox"/>	<u>Vascular Surgery</u> Endovascular Surgery: Complex Aorta <ul style="list-style-type: none"> - Endovascular repair of suprarenal abdominal aortic aneurysms (EVAR) with the use of fenestrated / branched devices 	
<input type="checkbox"/>	<u>Vascular Surgery</u> Endovascular Surgery: Thoracic Aorta <ul style="list-style-type: none"> - Endovascular repair of thoracic aorta (TEVAR) for thoracic / thoraco-abdominal aneurysms and dissections - TEVAR with fenestrated or branched devices 	
<input type="checkbox"/>	<u>Vascular Surgery</u> Endovascular Surgery: Cerebrovascular <ul style="list-style-type: none"> - Carotid angioplasty and stenting - Vertebral artery stenting 	

REQUESTED	PROCEDURE	INITIAL CRITERIA
(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)		
<input type="checkbox"/>	<u>Vascular Surgery</u> Endovenous Interventions: Basic <ul style="list-style-type: none"> - Procedures for varicose veins other than ligation / stripping and injection sclerotherapy - Radiofrequency ablation - Mechanical / chemical ablation - Endovenous glue therapy - High intensity focused ultrasound ablation 	5 years post fellowship or equivalent qualification for specialist training in general surgery or vascular surgery and be able to demonstrate that he/she has adequate experience in specific individual procedures
	<u>Vascular Surgery</u> Endovenous Interventions: Complex <ul style="list-style-type: none"> - Inferior vena cava filter insertion - Superior vena cava angioplasty and stenting - Lower limb venous thrombectomy and stenting - Upper limb venous thrombectomy and stenting - Venous thrombolysis 	

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 : _____