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 Hong Kong Hospital (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*			
Name in Chinese*			
HKID*			
Passport No. *(Please provide details if you do not possess a HKID card)*			
Country of Issue		Expiry Date	
Nationality^			
Date of Birth	DD / MM / YYYY		
Gender*	◯ Female	◯ Male	
Marital Status^	◯ Single	◯ Married	◯ 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 Tel No..:____ Home No.:____		
Emergency Contact Person	(1) Clinical Name:	Contact No.:	
	(2) Personal Name:		
	Relationship:	Contact No.:	
Business Address			
	Contact No.:	Fax No.:	
Residential Address			
Correspondence Address *(if different from the above address)*			
Current Appointment(s)^ *(any paid/unpaid appointment(s)to universities, public organizations or private organizations)*			

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 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 & Place	Name/ Type of Service Programme / 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:** University of Hong Kong or Chinese University of Hong Kong or Hospital Authority hospital	Educational Activities **Example:** Undergraduate Medical and Nursing students (for CUHK, HKU, 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	◯	◯	
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? ◯ Yes / ◯ No^. If Yes, please give details :

***Please ☑ as appropriate**

^Please delete as appropriate

PART C

Request for Privileges – Mental Health Services

<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 colspan="3">Core Privileges in Mental Health Services</td></tr>
<tr><td>☐</td><td colspan="2">Apply for ALL core privileges</td></tr>
<tr><td>☐</td><td>Admit, evaluate, diagnose, consult, perform history and physical exam, and provide treatment to patients presenting with mental, behavioral, or emotional disorders</td><td rowspan="8">Registered in the Specialist Register in Psychiatry (S24) 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 Psychiatry

AND

In active practice</td></tr>
<tr><td>☐</td><td>Consultation with physicians in other fields regarding mental, behavioral, emotional, and geriatric psychiatric disorders</td></tr>
<tr><td>☐</td><td>Psychopharmacology</td></tr>
<tr><td>☐</td><td>Providing individual, group and family therapy</td></tr>
<tr><td>☐</td><td>Consultation to the courts</td></tr>
<tr><td>☐</td><td>Emergency psychiatry</td></tr>
<tr><td>☐</td><td>Chemical dependency intervention and therapy</td></tr>
<tr><td colspan="3">Special Privileges in Mental Health Services
(must meet the criteria of Core Privileges as stated above)</td></tr>
<tr><td>☐</td><td>Electroconvulsive therapy</td><td rowspan="3">Proof of previous training or experience in administration as deemed satisfactory by COS

AND

In active practice</td></tr>
<tr><td>☐</td><td>Transcranial Magnetic Stimulation (TMS)</td></tr>
<tr><td>☐</td><td>Sleep studies</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 Hong Kong Hospital. 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 : _____