Gleneagles™ HONG KONG 港怡醫院

# Application for Clinical Privileges

- Basic pre-requisite for credentialing of all specialties requires the applicant being holder of a current valid Annual Practicising 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.

- 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) 2528 0028 or Email: credentialing@gleneagles.hk.

# PART A
# Personal Information

## 1. Applicant's Personal Particulars

| | | | | |
|---|---|---|---|---|
| Applicant's Name | | | | Photo |
| Name in Chinese^ | | | | |
| HKID | | | | |
| Passport No.<br>*(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 | |
| Mobile Phone No. | | | | |
| Email Address | | | | |
| Marital Status*^ | ◯ Single | ◯ Married | ◯ Divorced | |
| Emergency Contact Person | Name: | | | |
| | Relationship: | | Contact No.: | |
| Business Address | | | | |
| | Contact No.: | | Fax No.: | |
| Residential Address | | | | |
| Correspondence Address<br>*(if different from the above address)* | | | | |
| Current Appointment(s)^<br>*(any paid/unpaidappointment(s)to universities, public organizations or private organizations)* | | | | |

***Please ☑ as appropriate**
**^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;<br>- HGM:Medical Officer/Medical Officer Trainee/AssistantProfessor;<br>- HKS: Senior Medical Officer/Specialist/Associate Professor;<br>- HKC: Consultant/Professor/Director |
| Private Hospital Rates | - MOB: Obstetrics;<br>- COS: Cosmetic/aesthetic practice;<br>- INN: Neurosurgery;<br>- SHS: Super High Risk;<br>- VHR: Very High Risk;<br>- MHR: High Risk;<br>- INA: Anaesthetics;<br>- MMR: Medium Risk;<br>- MLR: Low Risk;<br>- PGM: GP Non Procedural– consultative office procedures and assisting;<br>- PGZ: GP Non Procedural– consultative office procedures and assisting;<br>- PGP: GP Procedural;<br>- PGO: GP Risk with obstetrics;<br>- XGP: Cosmetic and Aesthetic Medicine;<br>- NSM: Non-clinical: advisory services only<br>- PHY: Physiotherapist;<br>- DTC: Dietician;<br>- 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 (guidelines) / Clinic/ Skills<br><br>**Example:**<br>HA<br>Professional bodies (Colleges, Medical Councils, Professional Associations)<br>Private Hospital | Role of Involvement<br><br>**Example:**<br>As Council Member<br>As Chairman<br>As President<br>As Board Member |
|---|---|---|
| | | |

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

| Dates/ Periods | Name of Professional Body<br><br>**Example:**<br>University of Hong Kong<br>or<br>Chinese University of Hong Kong<br>or<br>Hospital Authority hospital | Educational Activities<br><br>**Example:**<br>Undergraduate Medical and Nursing students (for CUHK, HKU, PolyU or others)<br><br>Providing specialty training for Colleges of Hong Kong Academy of Medicine | Participation<br><br>**Example:**<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 | ◯ | ◯ | |
| 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 – Cardiology

| REQUESTED | PROCEDURE | INITIAL CRITERIA |
|---|---|---|
| **(Please ONLY ☑ the privileges you apply for)** | | |
| **Core Privileges in Cardiology** | | |
| ☐ | Apply for **ALL** core privileges | |
| ☐ | Cardioversion | Registered in the Specialist Register in Cardiology(S13) of the Medical Council of Hong Kong<br><br>AND<br><br>In active practice |
| ☐ | Coronary Angiography | |
| ☐ | Echocardiography | |
| ☐ | Holter monitoring | |
| ☐ | Intra Aortic Balloon Pump Insertion and Management | |
| ☐ | Non-invasive vascular tests | |
| ☐ | Pericardiocentesis (elective) & Balloon Percardiostomy | |
| ☐ | Pharmacological stress testing | |
| ☐ | Stress echocardiography | |
| ☐ | Swann-Ganz catheter insertion | |
| ☐ | Treadmill Stress ECG | |
| ☐ | Cardiac Catherisation | |
| ☐ | Temporary Cardiac Pacing | |
| ☐ | Peripheral Angiography | |
| ☐ | Percutaneous Myocardial Biopsy | |
| ☐ | Transosesophageal 2D/3D-Echocardiography | |
| ☐ | Sedation for Procedures | |

| REQUESTED | PROCEDURE | INITIAL CRITERIA |
|---|---|---|
| **(Please ONLY ☑ the privileges you apply for)** | | |
| **Special Privileges in Cardiology**<br>(must meet the criteria of Core Privileges as stated above) | | |
| ☐ | Cardiac Electrophysiology Studies (EPS) - Diagnostic & Interventional | Have for each type of procedure, satisfied relevant training requirements in this area<br><br>AND<br><br>Should have involved in a minimum of 100 invasive EPS cases (60 as primary operator) of which at least 50 procedures are ablative (30 as primary operator)<br><br>AND<br><br>In active practice |
| ☐ | Cardiac Resynchronisation Therapy (CRT) | Should have for each type of device, satisfied relevant training requirements in this area<br><br>AND<br><br>Should have performed ≥ 20 permanent CRT device implantation<br><br>AND<br><br>In active practice |
| ☐ | Coronary Balloon Angioplasty including Coronary Stenting/ Coronary Arthrectomy / Rotablation/ Intravascular Ultrasonography | Should have for each type of device, satisfied relevant training requirements in this area<br><br>AND<br><br>Should have Involved in a minimum of 150 cardiovascular interventional procedures Including 75 percutaneous cardiovascular intervention as primary operator<br><br>AND<br><br>In active practice |

| REQUESTED | PROCEDURE | INITIAL CRITERIA |
|---|---|---|
| **(Please ONLY ☑ the privileges you apply for)** | | |
| ☐ | ICD Implantation | Should have for each type of device, satisfied relevant training requirements in this area<br>AND<br>Should have performed ≥ 10 ICD Implantations<br>AND<br>In active practice |
| <u>Adult structural heart interventions</u> | | Should have for each type of device, satisfied relevant training requirements in this area<br>AND<br>Should have performed ≥ 20 of each requested procedures, including at least 10 procedures as primary operator<br>AND<br>In active practice |
| ☐ | • Percutaneous balloon mitral valvuloplasty (PBMV) | |
| ☐ | • Aortic valve balloon valvoplasty | |
| ☐ | • Occluder devices for atrial septal defect (ASD) | |
| ☐ | • Ventricular septal defect (VSD) | |
| ☐ | • Patent ductus arteriosus (PDA) | |
| ☐ | • Patent foramen ovale (PFO) | |
| ☐ | Permanent Pacemaker Implantation | Should have for each type of device, satisfied relevant training requirements in this area<br>AND<br>Should have performed ≥ 20 permanent pacemaker implantation<br>AND<br>In active practice |

| REQUESTED | PROCEDURE | INITIAL CRITERIA |
|---|---|---|
| **(Please ONLY ☑ the privileges you apply for)** | | |
| ☐ | Peripheral Transluminal Angioplasty / Stenting/ Thrombolysis , including Carotid Artery Intervention | Should have for each type of device, satisfied relevant training requirements in this area<br><br>AND<br><br>Should have involved in a minimum of 50 peripheral interventional procedures including 25 peripheral intervention as primary operator<br><br>AND<br><br>In active practice |

**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 (dd-mmm-yy):** _____

**Applicant Name :** _____