

## **Application for Clinical Privileges**

- Basic pre-requisite for credentialing of all specialties requires the applicant being holder of a current valid Annual Practising 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](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 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><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

^Optional

|                                                               |                              |                |
|---------------------------------------------------------------|------------------------------|----------------|
| <b>2. Academic Background</b>                                 |                              |                |
| University Attended                                           |                              |                |
| Degree Obtained                                               |                              |                |
| Year of Graduation                                            |                              |                |
| First registration with<br>Medical Council of Hong<br>Kong    | Date (year) :                |                |
|                                                               | Registration no.:            |                |
|                                                               | Qualification used:          |                |
| Other Quotable<br>Qualifications^                             | Date (year) :                | Qualification: |
|                                                               | Date (year) :                | Qualification: |
|                                                               | Date (year) :                | Qualification: |
|                                                               | Date (year) :                | Qualification: |
|                                                               | Date (year) :                | Qualification: |
| Medical Council of Hong<br>Kong Specialist<br>Registration    | Registered in (specialty):   |                |
|                                                               | Specialist Registration No.: |                |
| Fellowship of Hong Kong<br>Academy of Medicine<br>(specialty) |                              |                |
| Other Specialist<br>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 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; Place</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>University of Hong Kong<br>or<br>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 CUHK, HKU, 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                                                                                                                                               |         |      |                                           |
| 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 – Clinical Oncology**

| REQUESTED                                                                                                     | PROCEDURE                                                                                                                                                                                                                                                              | INITIAL CRITERIA                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <b>(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)</b>                         |                                                                                                                                                                                                                                                                        |                                                                                                                                           |
| <b>Core Privileges in Clinical Oncology</b>                                                                   |                                                                                                                                                                                                                                                                        |                                                                                                                                           |
| <input type="checkbox"/>                                                                                      | To admit, evaluate, diagnose, consult, perform history and physical examination and provide treatment or consultative services to patients of all ages presenting with malignant tumors or those in need of radiation treatment (for clinical/radiation oncology only) | Registered in the Specialist Register in Clinical Oncology (S26) of the Medical Council of Hong Kong<br><br>AND<br><br>In active practice |
| <b>Special Privileges in Clinical Oncology</b><br>(must meet the criteria of Core Privileges as stated above) |                                                                                                                                                                                                                                                                        |                                                                                                                                           |
| <input type="checkbox"/>                                                                                      | Administration of chemotherapy agents and biological response modifiers through all therapeutic routes                                                                                                                                                                 | Proof of relevant experience for high risk therapeutic routes, e.g. intrathecal<br><br>AND<br><br>In active practice                      |
| <input type="checkbox"/>                                                                                      | Prescription and administration of oral or intravenous drugs and medicines related to cancer supportive care                                                                                                                                                           | In active practice                                                                                                                        |
| <input type="checkbox"/>                                                                                      | Bone marrow aspiration and biopsy                                                                                                                                                                                                                                      | Proof of relevant experience<br><br>AND                                                                                                   |
| <input type="checkbox"/>                                                                                      | Management and maintenance of indwelling venous access catheters                                                                                                                                                                                                       | Endorsed by COS taking overall experience and competency into account                                                                     |
| <input type="checkbox"/>                                                                                      | Paracentesis                                                                                                                                                                                                                                                           | AND                                                                                                                                       |
| <input type="checkbox"/>                                                                                      | Thoracentesis                                                                                                                                                                                                                                                          | In active practice                                                                                                                        |

| REQUESTED                                                                                                                           | PROCEDURE                                                                  | INITIAL CRITERIA                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <b>(Please ONLY <input checked="" type="checkbox"/> the privileges you apply for)</b>                                               |                                                                            |                                                                                                                      |
| <input type="checkbox"/>                                                                                                            | Lumbar puncture                                                            | Proof of relevant experience<br><br>AND<br><br>Endorsed by COS taking overall experience and competency into account |
| <input type="checkbox"/>                                                                                                            | Fine needle aspiration of tumor mass                                       | AND<br><br>In active practice                                                                                        |
| <b>Special Privileges in Clinical Oncology or Radiation Oncology</b><br>(must meet the criteria of Core Privileges as stated above) |                                                                            |                                                                                                                      |
| <input type="checkbox"/>                                                                                                            | External beam radiation including stereotactic radiosurgery / radiotherapy | Proof of relevant experience<br><br>AND<br><br>In active practice                                                    |
| <input type="checkbox"/>                                                                                                            | Brachytherapy – unsealed source e.g. RAI, P32, strontium, Zevalin, SIRTEX  | Proof of relevant experience<br><br>AND                                                                              |
| <input type="checkbox"/>                                                                                                            | Brachytherapy – sealed source: intracavitary or interstitial treatment     | Endorsed by COS taking overall experience and competency into account                                                |
| <input type="checkbox"/>                                                                                                            | Diagnostic flexible fiberoptic nasopharyngolaryngoscopy                    | 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 :** \_\_\_\_\_