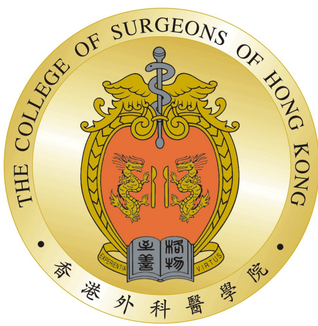


# THE COLLEGE OF SURGEONS OF HONG KONG

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99 Wong Chuk Hang Road, Aberdeen, Hong Kong
Tel: (852) 2871-8799 Fax: (852) 2515-3198 Email: info@cshk.org

## UPDATE OF PERSONAL INFORMATION

*Please fill out the form in typed-format or written in BLOCK LETTERS.

| Surname | | Given Name | |
|---|---|---|---|
| Name in Chinese | (if applicable) | | |
| Date of Birth | (dd/mm/yyyy) | | |
| Correspondence Address | | | |
| | | | |
| Permanent Address | | | |
| | | | |
| Contact Number | Mobile: | Home: | |
| | Office: | Pager: | |
| | Fax: | | |
| Email Address | | | |
| Specialty | | | |
| Current Practice (Please tick one) | □ Hospital Authority (Please specify ______) | | |
| | □ University Practice (Please specify ______) | | |
| | □ Private Hospital (Please specify ______) | | |
| | □ Private Practice (Please specify ______) | | |
| | □ Overseas (Please specify ______) | | |
| | □ Retired | | |

* The update of the above personal information will be effective from ______________(dd/mm/yy)

**DECLARATION**

I hereby declare that I agree to provide the above information to The College of Surgeons of Hong Kong for administrative purposes and the information provided in support of this application is accurate and complete.

I understand that it is my responsibility to inform the College for any change of personal particulars, e.g. Correspondence Address, Place of work, Email Address, etc. The College will not be responsible for any issues arise as a result of failure to inform the College.

______________________(Signature) ______________________(Date)