THE COLLEGE OF SURGEONS OF HONG KONG

Room 601, Hong Kong Academy of Medicine Jockey Club Building
99 Wong Chuk Hang Road, Aberdeen, Hong Kong
Tel: (852) 2871 8799 Fax: (852) 2515 3198 E-mail: info@cshk.org

APPLICATION FORM FOR TRAINER

IMPORTANT NOTES TO APPLICANTS:

Applicants must read the **"Guidelines on Trainer"** before completing this application form.

1. This application form should be typed or written in block letters. Please use separate sheets for details or explanations if necessary. The College will not process any incomplete application.

2. Applicants are requested to attach their **Curriculum Vitae (C.V.)** which is not returnable and will be verified in due course.

3. All information given in this form will be treated **STRICTLY CONFIDENTIAL**.

4. Application should be sent to:

   The College Secretariat (Trainer Application)
   The College of Surgeons of Hong Kong
   Rm 601, Hong Kong Academy of Medicine Jockey Club Building
   99 Wong Chuk Hang Road, Aberdeen, Hong Kong

   Application will only be processed in **June/December** every year.

5. For general enquiry, please contact the College Secretariat:

   Tel: (852) 2871 8799 Fax: (852) 2515 3198 Email: info@cshk.org

For Office Use

Applicant Name

_____

Approved by E&EC on

_____

Signature

_____

Approved by Council on

_____

Signature

_____

SPECIALTY: _____

I PERSONAL PARTICULARS

Surname:	Given Name (in full):
Name in Chinese (if applicable):	Date of Birth(dd/mm/yy):
Hong Kong I.D. Card No/ Passport No:	Sex: Female / Male (Please delete as appropriate)

*Correspondence Address:	Telephone Number
	Office:
	Res.:
Permanent Address:	Mobile:
	Pager:
	Fax:

*Email Address:

*** Remarks: Trainers are required to keep the College informed of the most updated Email Address and Correspondence Address. The College will not take any responsibility of the consequence if any message delivering to the above email address or correspondence address cannot reach them in the future.**

II PROFESSIONAL APPOINTMENTS

INSTITUTION	POSITION	EMPLOYMENT PERIOD		FULL TIME/ PART TIME
		FROM	TO	

➢ Are you currently engaging in any Surgical Training Programme for Higher Trainee? ☐ YES ☐ NO (Please tick as appropriate)

III MEDICAL QUALIFICATION (e.g. FRCS, FCSHK, FHKAM, etc.)	Date Obtained (Month / Year)

II CURRENT APPOINTMENT (Please tick as appropriate)

☐ HOSPITAL AUTHORITY (Please specify _____)

☐ UNIVERSITY (HKU / CUHK - Please delete as appropriate)

☐ PRIVATE - Date of commencement of practice _____(Month/ Year)

➢ Are you a Registered Medical Practitioner in Hong Kong? ☐ YES ☐ NO (Please tick as appropriate)

DECLARATION

1. **I declare that the information provided by me in this document and Curriculum Vitae (the "Information") is true and complete.**

2. **I consent to provide the Information and my personal data from time to time collected by the College of Surgeons of Hong Kong Limited (the "College") (all the Information and such personal data are together called "Personal Data") for the administration and management of the College and training, education, practice, professional accreditation and registration in relation to medicine.**

3. **I acknowledge and consent that in relation to the above-mentioned purposes my Personal Data may be transferred by the College to (a) the Hospital Authority, the Hong Kong Academy of Medicine, the Medical Council of Hong Kong, any hospitals, clinics or similar medical institutions providing medical treatment and health care and other professional and regulatory bodies related to medicine all of which may further share the use of such Personal Data amongst themselves and (b) other persons as required by law.**

4. **I acknowledge that it is my responsibility to inform the College in writing of any change in my Personal Data (e.g. correspondence address, place of work, email address etc.). The College will not be liable to me for any loss or damage that may arise or be incurred as a result of my failure to inform the College of such change in my Personal Data in a timely manner.**

_____(Signature of Applicant) _____(Date)

RECOMMENDATION BY THE PROGRAM SUPERVISOR OF THE TRAINING CENTRE

I would like to recommend Doctor/Professor _____(Name of Applicant) to

become trainer for Higher Surgical Training in _____(Specialty) in

_____ (Hospital/Institution).

(Stamp with Institution Chop)

Name: _____ Signature: _____
(BLOCK LETTERS)

Please send application to:

The College Secretariat (Trainer Application)
The College of Surgeons of Hong Kong
Rm 601, Hong Kong Academy of Medicine Jockey Club Building
99 Wong Chuk Hang, Aberdeen, Hong Kong

FOR OFFICE USE

APPROVAL FROM THE CHAIRMAN OF THE SPECIALTY BOARD

On behalf of the _____Specialty Board, I confirm that the applicant is our *BOARD MEMBER/ FELLOW *(*Please delete as appropriate)* of the Board and we would like to recommend him/her to become trainer of our Board.

Name: _____ Signature: _____
(BLOCK LETTERS)