***Please type your information into this word file (recommended)***

***Personal Information:*** Please submit 2 passport size photographs with your name written at the back

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name in English** | **(Name appeared on your HK ID Card)** | | |
| **Nickname** (if applicable) |  | **Name in Chinese** (if applicable) |  |
| **Sex #** | Male / Female | **Date of Birth** (day/month/year) |  |
| **HK ID Card / Passport No** |  | **HKMC Registration No.** |  |

# Please delete where inappropriate.

***Present Appointment:***

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| --- | --- | --- | --- |
| **Rank** |  | **Department** |  |
| **Hospital** |  | **Effect Date**  (day/month/year) |  |
| **Is Hong Kong Intercollegiate Board Of Surgical Colleges  Basic Surgical Trainee (HKICBSC BST)?** | | | Yes / No |

***Contact Information:***

|  |  |  |  |
| --- | --- | --- | --- |
| \* Mandatory | | \* Mandatory | |
| **Office** |  | **Office Address** |  |
| **Home\*** |  |
| **Mobile\*** |  | **Home Address\*** |  |
| **Pager** |  |
| **Fax** |  | **Other Address**  (if applicable) |  |
| **Email Address\*** |  |

***Medical Qualifications:*** Please submit **Certified True Copies** of **Medical Graduation Certificate**, **License of Registration** and **Annual Practicing Certificate** of Hong Kong Medical Council (HKMC).

| **Qualifications** | **Awarding Institutes** | **Date conferred** (day/month/year) |
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***Internship Experience:***

| **Starting Date**  (day/month/year) | **Ending Date**  (day/month/year) | **Hospital** | **Department** | **Remark** |
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***Professional Experience: (Local or Overseas)***

Please complete the section on **‘Application for Recognition of Local Professional Experience’** (Page 4 & 5) and enclose certified true copies of documents if appropriate

| **Starting Date**  (day/month/year) | **Ending Date**  (day/month/year) | **Hospital** | **Department** | **Rank** | **Remark** |
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# Please use separate sheet if needed

***Payment***

Enrollment Fee: HK$3,000; Registration Fee: HK$500 (January - December) / HK$250 (July - December);   
Logbook Delivery Method: Free (Self pick up at College) / $75 (Mail to Hospital by Courier);  
Payable to “**Hong Kong College of Emergency Medicine**”. Receipt will be collected with logbook.

|  |  |  |  |
| --- | --- | --- | --- |
| **Logbook Delivery Method #** | Self Pick Up at College / Mail to Hospital by Courier | **Amount** | HK$ |
| **Cheque Number** |  | **Bank** |  |

# Please delete where inappropriate.

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|  |  |  |
| Signature of Applicant |  | Signature of Training Supervisor |
|  |  |  |
| Name of Applicant |  | Name of Training Supervisor |
|  |  |  |
| Date of Application |  | Proposed Date of Registration |

|  |  |  |
| --- | --- | --- |
| * Please send the Word File of your completed Application Form  to [em-it@hkcem.org.hk](mailto:em-it@hkcem.org.hk) for input into trainee database **(recommended)** (Please protect your file by a **password**) | Password |  |
| * Please send the Hardcopy of Documents **by hand or mail** to  Hong Kong College of Emergency Medicine,  Room 809, Hong Kong Academy of Medicine,  99 Wong Chuk Hang Road, Aberdeen, HK | Check List for Hardcopy of Documents:  (1) Completed Application Form  (2) 2 Photographs  (3) Certified True Copies of Documents  (4) Cheque | |

***For Enquiry:*** 2871-8877 / 2552-1667

***For Official Use:***

|  |  |
| --- | --- |
| **Received Date of Application Form** |  |
| **Approved by Education Committee** |  |
| **Approved Date by Education Committee** |  |

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| --- | --- | --- | --- |
| **Receipt Number** |  |  |  |
| **Collection / Mailing Date of Logbook and Receipt** |  |  |
| Signature of Trainee  when collected logbook & receipt |

***Application for Recognition of Local Professional Experience***

(if applicable)

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| --- | --- | --- | --- | --- | --- | --- |
| 1 | Rank: |  |  | 2 | Rank: |  |
|  | Department: |  |  |  | Department: |  |
|  | Hospital: |  |  |  | Hospital: |  |
|  | Period: |  |  |  | Period: |  |
|  | Name of  Consultant: |  |  |  | Name of  Consultant: |  |
|  | Signature of  Consultant: |  |  |  | Signature of  Consultant: |  |
|  | Hospital  Stamp: |  |  |  | Hospital  Stamp: |  |
|  |  |  |  |  |  |  |
| 3 | Rank: |  |  | 4 | Rank: |  |
|  | Department: |  |  |  | Department: |  |
|  | Hospital: |  |  |  | Hospital: |  |
|  | Period: |  |  |  | Period: |  |
|  | Name of  Consultant: |  |  |  | Name of  Consultant: |  |
|  | Signature of  Consultant: |  |  |  | Signature of  Consultant: |  |
|  | Hospital  Stamp: |  |  |  | Hospital  Stamp: |  |

***Application for Recognition of Local Professional Experience***

(if applicable)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 5 | Rank: |  |  | 6 | Rank: |  |
|  | Department: |  |  |  | Department: |  |
|  | Hospital: |  |  |  | Hospital: |  |
|  | Period: |  |  |  | Period: |  |
|  | Name of  Consultant: |  |  |  | Name of  Consultant: |  |
|  | Signature of  Consultant: |  |  |  | Signature of  Consultant: |  |
|  | Hospital  Stamp: |  |  |  | Hospital  Stamp: |  |
|  |  |  |  |  |  |  |
| 7 | Rank: |  |  | 8 | Rank: |  |
|  | Department: |  |  |  | Department: |  |
|  | Hospital: |  |  |  | Hospital: |  |
|  | Period: |  |  |  | Period: |  |
|  | Name of  Consultant: |  |  |  | Name of  Consultant: |  |
|  | Signature of  Consultant: |  |  |  | Signature of  Consultant: |  |
|  | Hospital  Stamp: |  |  |  | Hospital  Stamp: |  |