***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:***

|  |  |  |  |
| --- | --- | --- | --- |
| **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) |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***Internship Experience:***

| **Starting Date**(day/month/year) | **Ending Date**(day/month/year) | **Hospital** | **Department** | **Remark** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

***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** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

# 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.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| 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 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** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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: |  |