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**For Office Use Only**

App. No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Rcvd: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vetting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Data Entd: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HONG KONG ACADEMY OF MEDICINE**

**CERTIFICATION FOR SPECIALIST QUALIFICATION (for Doctors/Dentists applying for Special Registration)**

***Applicant should read the Guidance Notes carefully and make sure that all essential information is enclosed with this form.***

I wish to apply for certification that my training and qualification are comparable to those of Academy Fellows in the specialty of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to facilitate my application for special registration to the Medical Council of Hong Kong (MCHK) / Dental Council of Hong Kong (DCHK) for practising in Hong Kong. I declare that all information submitted are true and correct.

A cheque for HK$\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Bank: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Cheque No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) is enclosed.

**Personal Particulars**

|  |  |  |  |
| --- | --- | --- | --- |
| Name in English: |  | Name in Chinese: |  |
|  | *Please underline surname.* | *(if applicable)* |  |
| HKID Card/Passport No.: |  | Expiry Date (if any): |  |
| Correspondence Address: |  |
|  |  |
|  |  |
|  |  |
| Email Address: |  |
| Contact Tel. No.: |  | Contact Fax No.: |  |

**Basic Medical/Dental Qualification**

|  |  |  |
| --- | --- | --- |
| Qualifications | Awarding Institutions | Date of Award |
|  |  |  |

**Other Qualifications / Overseas Specialist Registration+**

|  |  |  |
| --- | --- | --- |
| Qualifications | Awarding Institutions | Date of Award |
|  |  |  |

+ *Please list the qualifications which you think are comparable to that recognized by the Academy for the award of its Fellowship.*

**Professional Training and Appointments** (in chronological order, including current appointment)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospitals/Institutions | Departments | Positions | From/To*(dd/mm/yyyy)* | F/P\* | Duration Accredited for Training |
| Basic | Higher |
|  |  |  |  |  |  |  |

*\*Use separate sheets if space provided is not enough. Please use “F” or “P” to indicate full-time or part-time.*

**Information Enclosed**

|  |  |
| --- | --- |
| No. of sheets (copies of information on qualifications and training) enclosed with this form: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature: |  |  | Date: |  |

|  |
| --- |
| IMPORTANTAll information provided in this application/enrolment form will be used by the Academy for purposes relating to application process.  In addition, the Academy may use the collected data for statistical research and analysis.  The Academy may transfer the information to its Colleges, the Medical Council of Hong Kong and Dental Council of Hong Kong for the purpose of certification for Specialist Qualification.  Data held by the Academy will be kept confidential and safeguarded carefully.  Personal data will only be collected and used for purposes directly related to the services and activities of the said event, unless otherwise prior consent has been obtained from the applicant. Personal data will not be kept longer than the time needed for the intended purposes. All personal data will be destroyed if the application is unsuccessful.  |

***Notes:***

*1) Applicants are required to produce certified true copies of:*

*a) HKID card or passport; and*

*b) evidence for CME/CPD, qualifications and training (please refer to the Guidance Notes for details).*

***[The Academy staff cannot certify proof for applicants. Proof should be certified by a barrister, a solicitor, a notary public, a Fellow of the Academy, or a commissioner for oaths (if the applicant is resident of Hong Kong)]***

*2) Cheque should be made payable to “Hong Kong Academy of Medicine” and sent with completed form and supporting document to “10/F, HKAM Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong”. Please mark “Ref. CSQ” on envelope.*