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

CLINICAL ATTACHMENT PROGRAMME
EXAMINATION ELIGIBLE CANDIDATE REGISTRATION FORM

IMPORTANT NOTES TO APPLICANTS:

Applicants must read the **"Clinical Attachment Programme for Examination Eligible Candidate"** & **"Eligibility for Examination Eligible Candidate"** 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 **certified true copies** of the required documents as listed in the **"Eligibility for Examination Eligible Candidate"** to support information given in the application. These copies are not returnable and will be verified in due course.
3. **A crossed cheque of HKD 1,500** (Annual Registration Fee) should be made payable to "The College of Surgeons of Hong Kong **Limited**". The cheque will be returned to the applicant by post if the application is unsuccessful.

   ** Applicants pay for the registration fee through Telegraph Transfer should notify the College in advance and submit their transaction details together with the application form. Applicants should pay an additional amount of **HKD 200** for Bank charge if choosing to submit the registration fee through Telegraph Transfer.*

   ***Applicants are required to pay the registration fee annually within the first month of the year until they have completed their Clinical Attachment Programme.*
4. A processing fee of **HKD 100** will be charged for any unsuccessful application, including incomplete application (including insufficient postage). It is the applicant's responsibility to ensure that they fulfill the eligibility criteria, and to make sure all required documentation and fees are submitted by the required date. To avoid unnecessary delivery delay or unsuccessful delivery, it is the responsibility of the applicant to ensure that all mail items bear **sufficient postage** by **weight** and **mail format**.
5. All information given in this form will be treated **STRICTLY CONFIDENTIAL**.
6. Application should be sent to:
   The College Secretariat (EEC Registration)
   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

   After completion of the mandatory higher surgical training programme as stipulated by the respective Specialty Board, trainees must submit this EEC Registration Form to the College within the first month of the CAP. It is the responsibility of the applicant to make sure the application form reach our office on time. Late application or incomplete application (including insufficient postage) will not be accepted. No allowance will be made for postal or other delays. Failure to do so will render disqualification of sitting for the Fellowship Examination of their respective specialties. Application received will be acknowledged by email.
7. 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: EECs 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 EMPLOYMENT TYPE (Please tick below as appropriate)

☐ HOSPITAL AUTHORITY PERMANENT FULL TIME

☐ HOSPITAL AUTHORITY CONTRACT FULL TIME (CONTRACT FROM _____ TO _____)

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

PRINCIPAL HOSPITAL: _____

CURRENT TRAINING HOSPITAL: _____PERIOD OF TRAINING (dd/mm/yy): _____

III PREVIOUS TRAINING RECORD

HIGHER SURGICAL TRAINING PROGRAMME

HST SPECIALTY: _____ DATE OF COMPLETION: (dd/mm/yy) :_____

PRINCIPAL HOSPITAL: _____

HIGHER SURGICAL TRAINING EXPERIENCE PORTFOLIO

Year 1: _____

Year 2: _____

Year 3: _____

Year 4: _____

Year 5: _____

IV *FULL TIME/ PART TIME CLINICAL ATTACHMENT (*Please delete as appropriate)

HOSPTIAL/INSTITUION: _____ DATE OF COMMENCEMENT(dd/mm/yy): _____

The maximum period allowed for clinical attachment:

- 5 years - Cardiothoracic Surgery, Neurosurgery, Paediatric Surgery, Plastic Surgery, Urology
- 3 years - General Surgery

TO BE CERTIFIED BY TRAINER

NAME OF TRAINER: _____ Signature: _____

(BLOCK LETTERS) ***(Stamp with Institution Chop)***

DECLARATION

1. I declare that the information provided by me in this document (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)

I enclose a cheque (No.) for HK$ _____ made payable to "The College of Surgeons of Hong Kong **LIMITED**". I understand that if my application is unsuccessful, the cheque will be returned to me by post.

Fees

Annual Registration Fee HKD 1,500.

_____(Signature of Applicant) _____(Date)

Please send application to:
The College Secretariat (EEC Registration)
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

TO BE CERTIFIED BY THE CHAIRMAN OF THE RESPECTIVE SPECIALTY BOARD

This is to certify Dr. _____ (Name of Applicant) has been approved by the Specialty Board of

_____ as the Examination Eligible Candidate(EEC). He/She will commence his/her Clinical Attachment

effective from _____(dd/mm/yy).

Name: _____ Signature: _____

(BLOCK LETTERS)

Date: _____

THE COLLEGE OF SURGEONS OF HONG KONG

CHECKLIST FOR
EXAMINATION ELIGIBLE CANDIDATE REGISTRATION

Please ensure the followings are enclosed with the EEC Registration Form:

- ☐ **Curriculum Vitae (C.V.)**
- ☐ **A crossed cheque** of **HKD 1,500** (Annual Registration Fee) made payable to "The College of Surgeons of Hong Kong **Limited**"
- ☐ Certification from the Superintendent of private institution (if applicant is in private practice).
- ☐ **Certified True Copy of** other relevant examinations/qualifications(if any)
- ☐ **Sufficient postage** (otherwise the application will be treated as incomplete application which will **NOT** be processed.)