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

REGISTRATION FORM FOR SUBSPECIALTY TRAINING IN GENERAL SURGERY

IMPORTANT NOTES TO APPLICANTS:

Applicants must read the **"Guide to Subspecialty Training in General Surgery"** 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. You are requested to attach the following required documents to support information given in your application. These copies are not returnable and will be verified in due course.
   - **Curriculum Vitae (C.V.)**
   - **A crossed cheque of HKD 2,000** (Annual Registration Fee) in favor of "The College of Surgeons of Hong Kong **Limited**". The cheque will be returned to the applicant by post if the application is unsuccessful.

     **Applicants are required to pay the Registration Fee annually until they have completed their subspecialty training.
3. 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**.
4. All information given in this form will be treated as **STRICTLY CONFIDENTIAL**.
5. Application should be sent to:
   The College Secretariat (Subspecialty Trainee 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

   All applicants must submit the Registration Form to the College Secretariat within the first month of training. 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. Late submission will render the respective training period not recognized. Application received will be acknowledged by email.
6. 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 General Surgery Board on

_____

Signature

_____

Approved by E&EC on

_____

Signature

_____

Approved by Council on

_____

Signature

_____

SUBSPECIALTY OF TRAINING PROGRAMME: _____

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: Applicants 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 you in the future.**

II PROFESSIONAL APPOINTMENTS

INSTITUTION	POSITION	EMPLOYMENT PERIOD		FULL TIME/ PART TIME
		FROM	TO	

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

IV 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

TO BE COMPLETED BY SUPERVISOR OF THE TRAINING CENTRE

This is to certify that a subspecialty training post in _____(Subspecialty) has been offered to

Dr. _____ (Name of Applicant) in the Department of _____ of

_____ (Accredited Training Center/Institution) commencing from _____(dd/mm/yy)

(Stamp with Institution Chop)

Supervisor Name: _____ Signature: _____
(BLOCK LETTERS)

Date: _____

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 crossed 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 2,000.

_____(Signature of Applicant) _____(Date)

Please send application to:
The College Secretariat (Subspecialty Trainee 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

TO BE COMPLETED BY THE CHAIRMAN OF THE GENERAL SURGERY BOARD

This is to certify Dr. _____ (Name of Applicant) has been admitted by the General Surgery Board and has not contravened the Rules of Regulations stipulated by The College of Surgeons of Hong Kong. He/She will commence his/her Subspecialty Training in _____ (Accredited Training Center/Institution) effective from

_____(dd/mm/yy)

Name: _____ Signature: _____
(BLOCK LETTERS)

Date: _____

THE COLLEGE OF SURGEONS OF HONG KONG

CHECKLIST FOR SUBSPECIALTY TRAINEE REGISTRATION FORM

Please ensure the followings are enclosed with the Subspecialty Trainee Registration Form:

- ☐ **Curriculum Vitae (C.V.)**
- ☐ **A crossed cheque** with the amount of **HKD 2,000** payable to "The College of Surgeons of Hong Kong **Limited**"
- ☐ **Sufficient postage** (otherwise the application will be treated as incomplete application which will **NOT** be processed.)