



# 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

## APPLICATION FOR TRAINER FOR SUBSPECIALTY TRAINING IN GENERAL SURGERY

### IMPORTANT NOTES TO APPLICANTS:

1. This application form should be typed or written in block letters. Please use separate sheets for details or explanations if necessary. The CSHK will not process any incomplete application.
2. You are requested to attach the following supporting documents which are not returnable and will be verified in due course.
  - a) Curriculum Vitae (C.V.)
  - b) Certified true copy of the Certificate of Post-Fellowship in Subspecialty (for applicant who has undergone the subspecialty training only)
  - c) Log book/ operation record statistics in past 1 or 2 years (for applicant who has not undergone the subspecialty training)
3. All information given in this form will be treated **STRICTLY CONFIDENTIAL**.
4. Application shall be sent to:  
Chairman, General Surgery Board (Subspecialty Trainer Application)  
  
The College of Surgeons of Hong Kong  
  
601, Hong Kong Academy of Medicine Jockey Club Building  
  
99 Wong Chuk Hang Road  
  
Aberdeen, Hong Kong
5. For enquiry, please contact the CHSK Secretariat:  
  
Tel: 2871 8799 / Fax: 2515 3198 / Email: [info@cshk.org](mailto:info@cshk.org)

For Office Use

Applicant Name

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Approved by General Surgery Board on

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Signature

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Approved by E&EC on

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Signature

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Approved by Council on

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Signature

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**SUBSPECIALTY IN GENERAL SURGERY:** \_\_\_\_\_

**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 CSHK informed of the most updated Email Address. The CSHK will not take any responsibility of the consequence if any message delivering to the above email 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)

**II 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 (Please delete as appropriate)

**DECLARATION**

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

**RECOMMENDATION BY THE PROGRAM SUPERVISOR OF THE TRAINING CENTRE**

I would like to recommend Doctor/Professor \_\_\_\_\_ (Name of Applicant) to become trainer for Training in \_\_\_\_\_ (Subspecialty in General Surgery) in \_\_\_\_\_ (Hospital).

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
(BLOCK LETTERS)

**Please send application to:**

Chairman, General Surgery Board (**Subspecialty Trainer Application**)  
The College of Surgeons of Hong Kong  
601, Hong Kong Academy of Medicine Jockey Club Building  
99 Wong Chuk Hang, Aberdeen, Hong Kong

**FOR OFFICE USE**

**APPROVAL FROM THE CHAIRMAN OF THE GENERAL SURGERY BOARD**

On behalf of the General Surgery Board, I confirm that the applicant is our \*BOARD MEMBER/ FELLOW (\*Please delete as appropriate) of the Board and we would like to recommend him/her to become Subspecialty trainer of General Surgery Board.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
(BLOCK LETTERS)