THE COLLEGE OF SURGEONS OF HONG KONG

Reinstatement of Fellowship

I. Requirements for Reinstatement:

Reinstatement of the Fellowship of the College of Surgeons of Hong Kong shall be:

A. at the discretion of the Council,
B. upon payment of fees as determined by the College from time to time, and
C. subject to the following CME/CPD requirements:
    i) applicants will be required to have obtained at least 90 points within 36 months counting back from the date of application for reinstatement
    ii) subject to additional conditions other than those listed in (B) and (C) if Council thinks it is necessary

It is the responsibility of ex-Fellows applying for reinstatement to provide proof of their CME/CPD required in (c) above.

The College **will not** keep and search past CME/CPD records for ex-Fellows.

II. Application for Reinstatement:

To: The Honorary Secretary
The College of Surgeons of Hong Kong
Room 601, 6/F, Hong Kong Academy of Medicine,
99 Wong Chuk Hang Road,
Aberdeen, Hong Kong. (Fax: 2518 3200)

I write to apply for the reinstatement of my *Fellowship with the College of Surgeons of Hong Kong.

I was a Fellow of the _____. *(Specialty)* Below are my personal/contact details:

Name _____ HKID/Passport No. _____

(please underline the surname) (*enter the alphabet and the first 4 digits only)

Address _____ Email _____

_____ Tel _____

☐ I enclose cheques (cheque number _____) in the amount of HKD5000 for the administrative fee and HKD_____ being the outstanding annual subscription accrued over the lapse period from the date of withdrawal/removal to the date of application, for the captioned application.

Applicant's Declaration

*(*Delete as appropriate. If there is any such conviction, details must be enclosed with this form.)*

1) I confirm that I *have/have not been convicted of an offence punishable by imprisonment (in Hong Kong or outside Hong Kong).

2) I confirm that I *have/have not been found guilty of professional misconduct by the Medical Council of Hong Kong, Dental Council of Hong Kong or similar regulatory organisations elsewhere.

3) I declare that the information provided by me in this document (the "Information") is true and complete.

4) 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.

5) 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.

Signature of applicant

Date:

(Please send this completed form to the College Secretariat by post or by email at kilam@cshk.org or fax 2518 3200.)

For Office use ONLY:

Received date: _____

Name of Handling Staff: _____

Updated database: ☐

Updated personal folder: ☐

Copy to HKAM: ☐