

THE HONG KONG COLLEGE OF FAMILY PHYSICIANS
Application Form for Accreditation / Re-accreditation as Training Centre for
Community Based Training in Family Medicine

- Application of Training Centre Accreditation
 Application of Training Centre Re-accreditation

1. Name of Practice: _____

2. Address: _____

3. Telephone: _____ Fax: _____
4. Cluster Coordinator: _____

TRAINING SUPERVISOR IN CHARGE

(Please make photocopy of this page if there is more than one supervisor)

1. Name: _____ (In Charge)
Place and Year of Graduation: _____
2. Other Qualification (and year obtained): _____

3. Years of Experience in General Practice: _____
4. Number of Years in Present Practice (Please state the number of hours/week on-site):

5. Past Experience in Teaching/Training (if any): _____
6. Past Experience in Research (if any): _____
7. FHKAM (Family Medicine): *NO / YES _____
(Year obtained)
8. Status in HKCFP:
Fellow [] Full [] None []
Associate Member [] Affiliate Member []
9. Do the other members of your practice agree to have a trainee in the practice?
*Yes / *No / *Not applicable
10. Are there other members of your practice who may be clinical supervisors?
*Yes / *No / *Not applicable

If yes, please provide details of items 1 to 8 for each of them on supplementary sheets.

** delete as appropriate*

15. What is the normal booking rate per hour?

16. How many appointments are available each week in the practice?
.....

17. Is there a medical record system? Yes [] Manual* / computerized* / both*

18. Does your practice have an age/sex register and disease register?

Age/Sex Register Yes [] No []

Disease Register Yes [] No []

19. What special equipment for diagnosis and treatment are available at the practice?

e.g. ECG, peak flow meter, cauterisation machine

.....
.....
.....
.....

WORKLOAD

20. Please enter the following statistics:

	<i>Mon</i>	<i>Tues</i>	<i>Wed</i>	<i>Thurs</i>	<i>Fri</i>	<i>Sat</i>	<i>Sun</i>
A.M.							
P.M.							

21. Does your practice provide house calls/home visits?

Yes [] No []

If yes, please state the average number of visits per month

STAFF

22. Total number of paramedical and auxiliary staff:

Number

e.g. Receptionist:

Clerical:

Registered Nurse:

Enrolled Nurse:

Dispenser:

Others (please specify):

LIBRARY

23. Does your practice have a library?

Yes [] No []

24. Does your practice have Books and Journals in General Practice/Family Medicine?

Yes [] No []

EDUCATIONAL ACTIVITIES

25. Does your practice allow time for continuing medical educational activities?

Yes [] No []

Weekly / Monthly / Others: _____

26. Does your practice organize the following educational activities?

a. Small Group Discussion []

b. Tutorial []

c. Lecture/Seminar []

d. Journal Club []

e. Research Club []

f. Undergraduate Teaching []

g. Video-Tape Viewing Sessions []

h. Others (Please Specify) _____

I, on behalf of _____, apply for accreditation as a training centre for Community Based Training of the Vocational Training Programme organized by the Hong Kong College of Family Physicians.

Signature : _____

Name : _____

(Block Letters, Please)

Date : _____

- END -