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

☐ Application of Training Centre Accreditation
☐ Application of Training Centre Re-accreditation
Expiry Date of Accreditation (mmm/yyyy): _____

1. Name of Hospital: .....

.....

2. Address: .....

.....

3. Telephone: ..... Email: .....

4. Cluster FM Department COS or Coordinator delegated: **(Name)** **(Position)**

5. Hospital Chief Executive or delegated: **(Name)** **(Position)**

6. Any **Basic** Trainee(s) working in the training centre in the preceding 12 months:

   Yes [ ] No [ ]

7. Any **Basic** Trainee(s) working in the training centre in the coming 12 months:

   Yes [ ] No [ ]

Those with no Basic Trainees in the preceding/coming 12 months, will be automatically accredited as Provisional training centre and no application is needed. Please return this page to BVTS for further arrangement. Should you have any queries, you are welcome to contact our secretariats at 2871 8899 or BVTS@hkcfp.org.hk.

If yes, please proceed to the next page.

COORDINATOR / PERSON APPLY ON BEHALF OF HOSPITAL / UINT (Same as item 4 above)

1. Name: ..... (☐ In Charge)

2. Place and Year of Graduation: .....

3. Other Qualification (and year obtained): .....

.....

4. Years of Experience in General Practice: .....

5. Position held in Current FM Specialty: .....

6. Past Experience in Teaching/Training and Research (if any): .....

.....

.....

7. Status in HKCFP:

Fellow [ ] Full [ ] None [ ]

Associate Member [ ] Affiliate Member [ ]

8. Do the other members of the hospital/unit agree to have trainees in the hospital/unit?

*Yes / *No

** delete as appropriate*

9. Please indicate the specialties you hope to accredit in your hospital and please list the names and Qualifications of clinical supervisors of the specialty.

Specialty	Name	Qualifications

DESCRIPTION OF THE HOSPITAL

10. Types of Hospital:

Hospital Authority Hospital: HKE [ ] HKW [ ]

KC [ ] KE [ ] KW [ ]

NTE [ ] NTW [ ]

Teaching Hospital of medical faculty of university [ ]

Private Hospital [ ]

Others [ ] .....

Please specify

11. Please describe the main geographical, social and environmental features of the hospital, including any local health conditions of special interest (e.g. occupational problems):

.....

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.....

.....

.....

.....

HOSPITAL ORGANIZATION

12. Is there a General Outpatient Clinic associated with the hospital?

    YES [ ], is it a HKCFP accredited community-based training centre? Yes [ ] / No [ ]

    NO [ ]

STAFF

13. Current number of Doctors: .....
14. Current number of paramedical / auxiliary staff: .....

EDUCATIONAL RESOURCES and ACTIVITIES

15. Does your Hospital have a library?

    Yes [ ], Available as Physical/Electronic/Both No [ ]

16. Are e-Journals and e-books count?

    Yes [ ], Available as Hard copy/Electronic/Both No [ ]

17. Would your hospital allow trainees protected time away to attend Family Medicine Seminars?

    Yes [ ] No [ ]

18. Would your hospital allow protected time for continuing medical educational activities?

Yes [ ] No [ ]

19. 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

** delete as appropriate*

I, on behalf of _____, apply for accreditation as a training centre for Hospital Based Training of the Vocational Training Programme organized by the Hong Kong College of Family Physicians. My preference timeslots for the visit would be:

	Mon	***Tue***	***Wed***	***Thur***	***Fri***	***Sat***	***Sun***
A.M.							
P.M.							

Signature : _____

Name : _____

(Block Letters, Please)

Date : _____

- END -