



香港家庭醫學學院
The Hong Kong College of Family Physicians

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APPLICATION FORM FOR ASSOCIATE MEMBERSHIP

(Ver. 1 August 2018)

- New Application Transfer from Category of Membership _____ (please Specify)
- Reactivate of Membership _____ (Member ID)

Please note that in order to allow adequate time for processing, only applications received by the end of each month will be assessed in the council meeting of the following month.

College's online membership directory[^] is for public education and public access. It is approved by the Medical Council of Hong Kong. Please indicate your consent on the below information online by make a ✓ into the boxes of each item. The information listed below would not be published unless your consent is received. Items with would not be published.

PERSONAL PARTICULARS: (* Items are Mandatory)

- Name in English*: _____
(Surname first, Block Letters, Please)
- Name in Chinese: _____ Gender*: _____
- Category of Membership (e.g. Associate Member, Full Member, Fellowship etc.)
- I.D. Card No*: _____ Date of Birth*: ____/____/____
DD MM YYYY
- Address of Practice:(English) _____
(Chinese) _____
- Nature of Practice: HA (Hospital/GOPD) / DH / Private (Hospital/OPD/Solo/Group) / Institute / UHS / NGO Medical Group / Other: _____ (Please circle)
- Practice Telephone No.: _____ Home Telephone No.: _____
- Mobile Phone No.*: _____ Fax No.: _____ (Work/Home)
(Please circle)
- E – Mail Address*: _____
- Correspondence Address* (Home/Work - please circle)
- English (Mandatory): _____

- Chinese: _____

DEGREES AND OTHER QUOTABLE QUALIFICATIONS:

(As approved by the Hong Kong Medical Council)

Qualification	Date Obtained	Granting Authority

REGISTRATION:

Registration Authorities	Registration Number	Date of Full Registration
Hong Kong Medical Council		

TRAINING AND EXPERIENCE:**Hospital Appointments:**

Date		Hospital	Appointment & Remarks
From	To		

General Practice Experience:

Date		Place	#Type of Practice (Appointment of applicable)	Full/Part Time
From	To			

Type of Practice: Solo Practice/Group Practice/Private/Government/Institutional/Others (Please specify)

CURRENT APPOINTMENTS:

Appointment	Institution/Practice

PARTICULARS OF ACADEMIC ACTIVITIES: (Publications/Experience in teaching/Scholarships or prizes:)

PARTICULARS IN ADMINISTRATIVE EXPERIENCE:

Offices held in medical associations and societies:

Other community services:

PARTICULARS OF MEMBERSHIP OF MEDICAL OR RELATED ORGANIZATIONS:

Type of Membership	Organization

I desire to become an Associate Member of The Hong Kong College of Family Physicians, and I hereby give an undertaking that, on admission to the Hong Kong College of Family Physicians, I will:-

- (i) uphold and promote to the best of my ability the aims and objectives of the College;
- (ii) observe and comply with the provisions of the Memorandum and Articles of Association and such Regulations and Bye-laws of the College as may from time to time be in force; and
- (iii) undertake and continue approved post-graduate study while I remain in active practice in family medicine.

I hereby enclose a cheque being ****Entrance Fee (new application)/Handling Fee for Reinstatement or Reactivation HK\$850.00** and annual subscription fee **HK\$400.00 (for first 3 years after graduation) / HK\$800.00** for year _____.
<** Please delete as appropriate>

I consent the Hong Kong College of Family Physicians (HKCFP) using, holding, storing and disclosing my personal data for all academic and administrative purposes under HKCFP’s Personal Data (Privacy) Policy which is accessible at www.hkcfp.org.hk.

Date: _____ Signature: _____

Full Name: _____

The following to be completed by two nominators, who are registered medical practitioners of good standing and who know the above named personally and believe him/her to be a suitable person to be elected an Associate Member of the Hong Kong College of Family Physicians. The proposer must be a Full Member/Fellow of the College.

*** Nominators are not required for Student Members applying for transfer to Associate Membership.**

Name of Proposer: _____ (Member I.D.) _____ Signature: _____
(Surname first, Block letters please)

Name of Seconder: _____ (Member I.D.) _____ Signature: _____
(Surname first, Block letters please)

Please return this form to: The Hon. Secretary, The Hong Kong College of Family Physicians, Rm 803-804, HKAM Jockey Club Bldg., 99 Wong Chuk Hang Road, Aberdeen, Hong Kong with:

- 2 passport size photos
- a cheque for your entrance and subscription fee payable to “**The Hong Kong College of Family Physicians**” which will be returned in case of unsuccessful application
- a copy of your annual practising certificate issued by the Hong Kong Medical Council
- a copy of your graduation certificate

For Office Use Only

Received -
Entrance/Reactivate Fee HK\$ _____ and Annual Subscription HK\$ _____ for the year _____.

Recommended / Not recommended by Membership Committee

Signed _____ Date: _____
Membership Committee

Approved by the Council on _____

**HKCFP Online Membership Directory –
For members registered with the Hong Kong Medical Council**

The HKCFP promotes the role of the Family Physician in the community. We are providing a voluntary membership directory for the general public on our website to further achieve this aim. Thank you all who have given the consent to make the directory a success.

As a member of the HKCFP, we wish to include you on this list, so as to allow the general public to find a Family Physician in their district or community.

The information listed would not be published unless we have your clear instruction of consent. By doing so, you are voluntarily consenting to have this information available for the general public.

The College will update the online membership directory regularly. If you wish to update or add your practice information in the online membership directory later, please kindly contact the College secretariat to obtain a form.

By Email: membership@hkcfp.org.hk

By Fax: 2866 0616