



The Hong Kong College of Orthopaedic Surgeons 香港骨科醫學院

REGISTRATION FORM FOR HIGHER ORTHOPAEDIC TRAINING

Name : _____
(Family Name, Given Names) (In Chinese)

Sex : _____ Date of Birth : _____ (dd/mm/yy)

HKID No. : _____ MCHK No. : _____

Correspondence Address : _____

Contact No.: _____ Pager No. : _____ Mobile : _____

E-mail Address : _____ Fax No. : _____

Qualifications *(Please provide the certified true copies of relevant evidence)*

Basic Medical Degree(s)			
Qualifications	Institute	Country	Date (dd/mm/yy)
Intermediate Qualification(s)			
Qualifications	Institute	Country	Date (dd/mm/yy)

Training Experience

Institute	Specialty	Supervisor	Date (dd/mm/yy)

TO BE CERTIFIED BY TRAINING DIRECTOR

This is to certify that Dr. _____ is offered a training post in our department effectively from _____ (dd/mm/yy) in _____ (Specialty/Hospital).

Name : _____ Signature : _____

Position : _____ Hospital : _____ Date : _____

I DECLARE THAT I AM A REGISTERED MEDICAL PRACTITIONER OF HONG KONG AND ORDINARILY RESIDE IN HONG KONG, AND ALL THE ABOVE INFORMATION ARE CORRECT.

Cheque No.: _____ Trainee's Signature: _____ Date: _____