THE HONG KONG COLLEGE OF ORTHOPAEDIC SURGEONS

香 港 骨 科 醫 學 院

REGISTRATION FORM FOR REHABILITATION SUBSPECIALTY 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. : _____

For the following items, please provide relevant certificates (use additional sheets if required)

Date of Election as Fellow of the Hong Kong College of Orthopaedic Surgeons : _____

Additional postgraduate degrees and qualifications (if applicable)

Qualification	Institution	Country	Duration of study/training	Year

TO BE CERTIFIED BY ORTHOPAEDIC REHABILITATION SUBSPECIALTY TRAINER

This is to certify that Dr. _____ is offered a subspecialty training post in our department effectively from ____/____/____(dd / mm / yy) in _____ (Training Centre).

He/She will be undergoing the first training in _____ (Training Centre) from ____/____/____(dd / mm / yy) to ____/____/____(dd / mm / yy).

Name : _____ **Signature:** _____

Position : _____ **Training Centre :** _____

Date : _____

Trainee's Signature:_____ **Date:**_____

✉ **Return Address:**
The Secretariat, The Hong Kong College of Orthopaedic Surgeons, Room 905, 9/F, Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong
☎ (852) 2871 8722