



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. _____ will undergo Orthopaedic Rehabilitation
 Subspecialty Training in our department effectively from ____ / ____ / ____ (dd / mm / yy) in
 _____ (Training Centre).

Name : _____ Signature: _____

Position : _____ Training Centre : _____

Date : _____

A crossed cheque in **HK\$2,000** (Cheque No. _____) made payable to
 "The Hong Kong College of Orthopaedic Surgeons" for annual training fee is enclosed.

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