

Registration Form for Higher orthopaedic training

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| --- | --- | --- | --- | --- |
| Name | : |  |  |  |
|  |  | (Family Name, Given Names) |  | (In Chinese) |

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| --- | --- | --- | --- | --- | --- |
| Sex | : |  | Date of Birth | : | (dd/mm/yy) |
|  |  |  |  |  |  |
| HKID No. | : |  | MCHK No. | : |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Correspondence Address : | |  | | | | |
|  | | | | | | |
|  |  | |  |  |  |  |
| Contact No.: |  | | Pager No. : |  | Mobile : |  |

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| --- | --- | --- | --- | --- |
| E-mail Address : |  | Fax No. | : |  |

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

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| **Basic Medical Degree(s)** | | | |
| Qualifications | Institute | Country | Date (dd/mm/yy) |
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|  |  |  |  |
| **Intermediate Qualification(s)** | | | |
| Qualifications | Institute | Country | Date (dd/mm/yy) |
| MHKICBSC | HKICBSC |  |  |
|  |  |  |  |
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**Training Experience**

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| Institute | Specialty | Supervisor | Date (dd/mm/yy) |
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### 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:**