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)
MHKICBSC	HKICBSC		

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:_____

✉ **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