THE HONG KONG COLLEGE OF FAMILY PHYSICIANS
Application Form for Accreditation / Re-accreditation as Training Centre for <u>Hospital Based Training</u> in Family Medicine

☐ Application of Training Centre Accreditation
☐ Application of Training Centre Re-accreditation

1. Name of Hospital: .....

.....

2. Address: .....

.....

3. Telephone: ..... Fax: .....

4. Cluster Coordinator: .....

<u>COORDINATOR / PERSON APPLY ON BEHALF OF HOSPITAL / UINT</u>

1. Name: ..... (☐ In Charge)

2. Place and Year of Graduation: .....

3. Other Qualification (and year obtained): .....

.....

4. Years of Experience in General Practice: .....

5. Main Field of Specialty: .....

6. Number of Years in Present Practice: .....

7. Position held in Present Specialty: .....

8. Past Experience in Teaching/Training (if any): .....

.....

.....

9. Past Experience in Research (if any): .....

.....

.....

10. Status in HKCFP:

Fellow [ ] Full [ ] None [ ]

Associate Member [ ] Affiliate Member [ ]

11. Do the other members of your hospital/unit agree to have trainees in the hospital/unit?

*Yes / *No

** delete as appropriate*

12. Please indicate the specialties you hope to accredit in your hospital and please list the names and Qualifications of clinical supervisors of the specialty.

Specialty	Name	Qualifications

DESCRIPTION OF THE HOSPITAL

13. Types of Hospital:

Hospital Authority Hospital: HKE [ ] HKW [ ]

KC [ ] KE [ ] KW [ ]

NTE [ ] NTW [ ]

Teaching Hospital of medical faculty of university [ ]

Private Hospital [ ]

Others [ ] .....

Please specify

14. Please describe the main geographical, social and environmental features of the hospital, including any local health conditions of special interest (e.g. occupational problems):

HOSPITAL ORGANIZATION

15. Is there a General Outpatient Clinic associated with the hospital?

    Yes [ ] No [ ]

16. Is there an appointment system in your General / Specialist Outpatient Clinic?

    YES [ ] *Full / *Partial

    NO [ ]

17. What is the normal booking rate per hour? .....

18. What type of medial record system does your hospital currently utilise?

    YES [ ] *Manual / *Computerized / *Both

    NO [ ]

19. Does your hospital have an age / sex register and disease register?

    Age / Sex Register YES [ ] NO [ ]

    Disease Register YES [ ] NO [ ]

20. What special equipment for diagnosis and treatment are available at your hospital?

    e.g. E.G.G., peak flow meter, cauterization machine

    .....

STAFF

21. Current number of Doctors: .....

22. Current number of paramedical / auxiliary staff:

** delete as appropriate*

	Type	Number
e.g.	Receptionist:	.....
	Clerical:	.....
	Registered Nurse:	.....
	Enrolled Nurse:	.....
	Dispenser:	.....
	Others (please specify):	.....

23. Any FM Trainees in coming six months: .....

LIBRARY

24. Does your Hospital have a library?

    Yes [ ] No [ ]

25. Does your practice have Books and Journals in General Practice/Family Medicine?

Yes [ ] No [ ]

26. How many books does your library contain approximately: .....

EDUCATIONAL ACTIVITIES

27. Would your hospital allow protected time for continuing medical educational activities?

Yes [ ] No [ ]

If YES, please specify time allowed: ..... hour(s) per week* / month*

28. Would your hospital allow trainees time away to attend Family Medicine Seminars at other centres?

Yes [ ] No [ ]

29. Does your practice organize the following educational activities?

a. Small Group Discussion [ ]

b. Tutorial [ ]

c. Lecture/Seminar [ ]

d. Journal Club [ ]

e. Research Club [ ]

f. Undergraduate Teaching [ ]

g. Video-Tape Viewing Sessions [ ]

h. Others [ ] .....

Please Specify

** delete as appropriate*

I, on behalf of _____, apply for accreditation as a training centre for Hospital Based Training of the Vocational Training Programme organized by the Hong Kong College of Family Physicians.

Signature : _____

Name : _____

(Block Letters, Please)

Date : _____

- END -