



THE HONG KONG COLLEGE OF ANAESTHESIOLOGISTS

PM

Registered address: Room 807, HKAM Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong
 Telephone: 2871-8833 Fax: 2814-1029

FELLOWSHIP APPLICATION FORM (Please use BLOCK LETTERS)

I wish to apply for Fellowship in Pain Medicine of the Hong Kong College of Anaesthesiologists.
 My personal details are as follows:

Section A

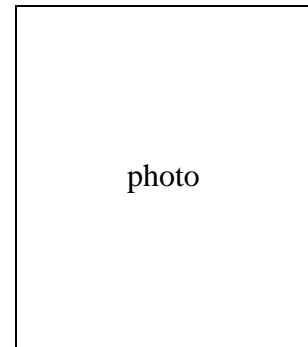
Surname: _____ Forename: _____ Chinese (if available): _____

Sex: M F HKID: _____

Telephone: _____ E-mail address: _____

Current appointment and Hospital: _____

Correspondence address: _____



Section B

BASIC MEDICAL QUALIFICATIONS	INSTITUTION, CITY, COUNTRY	DATES (MM / YY)

POSTGRADUATE & PROFESSIONAL QUALIFICATIONS	INSTITUTION, CITY, COUNTRY	DATES (MM / YY)

(Use additional sheets if space is not adequate)

Section C

Yes No

- 1. I have completed 3 years of basic training in an approved specialty. Yes No
- 2. I have passed the intermediate examination. Yes No
- 3. I have completed 3 years of higher training with 24 months of full time vocational training in pain medicine. Yes No
- 4. I have passed the final fellowship examination. Yes No
- 5. I have completed the formal project. Yes No
- 6. I have the following clinical exposure during my vocational training :
 - A. Acute pain cases (minimum 400 new cases) _____ cases
 - B. Chronic non-cancer pain cases (minimum 200 new cases) _____ cases
 - C. Cancer pain or palliative care cases (minimum 100 new cases) _____ cases
 - D. Interventional procedures (minimum 100 new cases) _____ cases
- 7. I have attended 24 sessions of inter/multi-disciplinary pain management Yes No
- 8. I have attended communication, counselling and psychological pain management training Yes No

FOR FELLOWSHIP *ad eundem* APPLICANTS WHO ARE NOT HKCA FELLOW / TRAINEE: Please enter the following Training Record in chronological order, including internship, and state whether the appointments listed below, were recognized for specialist training by the relevant overseas institution during the period concerned.

Appointment	Hospital (Dept/Unit)	City/Country	from: (dd/mm/yy)	to: (dd/mm/yy)	percentage of pain medicine clinical duties

(use additional sheet if space is not adequate)

Certified photocopies of the following documents are enclosed with the application (for Fellowship *ad eundem* only):

- 1. Specialist Qualification (s).
- 2. Evidence of appointment from the institution(s) listed above.

Section D

- ✧ I acknowledge that the information provided in the application form and supporting documents are complete and correct.
- ✧ I understand that if I give false or misleading information, my application may be refused.
- ✧ I understand that the information provided should be verifiable, and that applicants may be invited to submit further information to substantiate their application.

Date: _____

Signature of applicant _____