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

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

1. Name of Practice: .....

.....

2. Address: .....

.....

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

4. Cluster Coordinator: .....

TRAINING SUPERVISOR IN CHARGE
(Please make photocopy of this page if there is more than one supervisor)

1. Name: ..... (☐ In Charge)

   Place and Year of Graduation: .....

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

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

4. Number of Years in Present Practice (Please state the number of hours/week on-site):

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

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

7. FHKAM (Family Medicine): *NO / YES .....
   (Year obtained)

8. Status in HKCFP:

   Fellow [ ] Full [ ] None [ ]

   Associate Member [ ] Affiliate Member [ ]

9. Do the other members of your practice agree to have a trainee in the practice?

   *Yes / *No / *Not applicable

10. Are there other members of your practice who may be clinical supervisors?

    *Yes / *No / *Not applicable

    If yes, please provide details of items 1 to 8 for each of them on supplementary sheets.

    ** delete as appropriate*

THE PRACTICE

11. Types of Practice:

Hospital Authority Hospital: HKE [ ] HKW [ ]

KC [ ] KE [ ] KW [ ]

NTE [ ] NTW [ ]

Department of Health [ ] Institutional [ ] University [ ]

Private Hospital [ ] Private Solo [ ] Private Group [ ]

Others [ ] .....

Please specify

12. Total number of doctors working in the practice (providing general practice service):

Full time: .....

Part-time/sessional: .....

Maximum number of Trainees: .....

13. Please describe the main geographical, social and environmental features of the practice, including any local health problems: e.g. occupational problems

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PRACTICE ORGANIZATION

14. Is there an appointment system?

Yes [ ] Full* / Partial*

No [ ]

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

16. How many appointments are available each week in the practice?

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17. Is there a medical record system? Yes [ ] Manual* / computerized* / both*

18. Does your practice have an age/sex register and disease register?

Age/Sex Register Yes [ ] No [ ]

Disease Register Yes [ ] No [ ]

19. What special equipment for diagnosis and treatment are available at the practice?

e.g. ECG, peak flow meter, cauterisation machine

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WORKLOAD

20. Please enter the following statistics:

	Mon	***Tues***	***Wed***	***Thurs***	***Fri***	***Sat***	***Sun***
A.M.							
P.M.							

21. Does your practice provide house calls/home visits?

Yes [ ] No [ ]

If yes, please state the average number of visits per month .....

STAFF

22. Total number of paramedical and auxiliary staff: .....

Number

e.g. Receptionist: .....

Clerical: .....

Registered Nurse: .....

Enrolled Nurse: .....

Dispenser: .....

Others (please specify): .....

LIBRARY

23. Does your practice have a library?

    Yes [ ] No [ ]

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

    Yes [ ] No [ ]

EDUCATIONAL ACTIVITIES

25. Does your practice allow time for continuing medical educational activities?

    Yes [ ] No [ ]

    Weekly / Monthly / Others: _____

26. 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) _____

    _____

    _____

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

Signature : _____

Name : _____

(Block Letters, Please)

Date : _____

- END -