Appendix A

APPLICATION FORM

Application for Enrolment as a Colonoscopy Specialist in the Colorectal Cancer Screening Programme

Enrolment reference number:* _____

* *This number is automatically retrieved for online enrolment. For paper enrolment, please leave this field blank.*

To: The Government of the Hong Kong Special Administrative Region ("Government") as represented by the Director of Health

I, the person whose particulars appear in Section (A) of Part I below ("**Applicant**"), hereby apply to the Government to enrol as a colonoscopy specialist in the Colorectal Cancer Screening Programme ("**the Programme**").

The definitions and rules and interpretation set out in the Definitions at the Definitions, Terms and Conditions of Agreement for Colonoscopy Specialist (Appendix C) with respect to the Programme shall apply to this Application Form (Appendix A).

Part I – Application and Particulars of the Applicant and Health Care Provider

I, the person whose particulars appear in Section (A) below ("**Applicant**"), provide the following information in support of this application –

(A) Personal Particulars

Name of Applicant (as shown on Hong Kong Identity Card)

(English): _____ (Chinese): _____

Hong Kong Identity Card No.:_____

Correspondence address: _____

(Please provide documentary proof of correspondence address such as public utility bill or bank statements, and a copy of Hong Kong Identity Card).

Contact email address: _____

Daytime contact telephone number: _____

Fax: _____ (Optional)

(B) Particulars of Profession

I am practising as a registered medical practitioner (within the meaning of the Medical Registration Ordinance (Cap. 161)) who holds a valid practising certificate issued under the Ordinance (Professional Registration Number*:_____);
and a registered specialist of Gastroenterology & Hepatology in the Specialist Register within the meaning of the Ordinance (Specialist Registration Number*:_____)
or a registered specialist of General Surgery in the Specialist Register within the meaning of the Ordinance (Specialist Registration Number*:_____)

* *Professional Registration Number and Specialist Registration Number are the numbers assigned by the Medical Council of Hong Kong to the Applicant upon registration.*

(C) Particulars of Enrolment in the Electronic Health Record Sharing System (eHRSS)

I have enrolled in the eHRSS. My Electronic Health Record (eHR) User ID is _____

(D) Particulars of Enrolment in the Primary Care Directory (maintained by the Primary Healthcare Commission under the Health Bureau of the Government)

I have / have not enrolled in the Primary Care Directory.

Prerequisite for Government-subsidised Primary Healthcare Programmes
The Government requires doctors participating in Government subsidised primary healthcare programmes, including inter alia, the Colorectal Cancer Screening Programme (CRCSP), to be enlisted in the Primary Care Directory with effect from 6 October 2023. For further details and enrolment on the Primary Care Directory, please refer to https://www.pcdirectory.gov.hk/files/pre_requisite_for_gov_subsidised_ph_programmes.pdf.

(E) Health Care Provider

(The meaning of Health Care Provider can be found in the Definitions section at Appendix C. A separate Appendix A should be completed for each Health Care Provider of the same Applicant.)

Name of Health Care Provider:

(English): _____

(Chinese): _____

Business Registration Number**: _____

** *Please provide copy of Certificate of Business Registration of the Health Care Provider*

eHR "Healthcare Provider Identifier (HCP ID)": _____

(F) Relationship between parties

The relationship between me and the Health Care Provider is

☐ Sole proprietor of the Health Care Provider

☐ Partner of the Health Care Provider

☐ Shareholder of the Health Care Provider

☐ Directorof the Health Care Provider

☐ Employee of the Health Care Provider

☐ Others (please specify): _____

(G) Health Care Institution and Co-payment fee

The name(s) under which I practise the above profession, the address(es) and telephone number(s) of the Health Care Institution* (HCI) and the Co-payment fee(s)^ charged is / are:

(1) HCI* Name (English): _____

HCI* Name (Chinese): _____

Address (English): _____

Address (Chinese): _____

District: _____ (according to District Administration delineation)

Telephone number: _____

Service provided: ☐ Pre-procedural Consultation ☐ Colonoscopy Examination ☐ Both

Co-payment fee (with polypectomy)^ (if any): _____

Co-payment fee (without polypectomy)^ (if any): _____

Bank account number#: _____

eHR "Healthcare Institution Identifier (HCI ID)":_____

Charity quota: _____ per month

(2) HCI* Name (English): _____

HCI* Name (Chinese): _____

Address (English): _____

Address (Chinese): _____

District: _____ (according to District Administration delineation)

Telephone no.: _____

Service provided: ☐ Pre-procedural Consultation ☐ Colonoscopy Examination ☐ Both

Co-payment fee (with polypectomy)^ (if any): _____

Co-payment fee (without polypectomy)^ (if any): _____

Bank account number#: _____

eHR "Healthcare Institution Identifier (HCI ID)": _____

Charity quota: _____ per month

(3) HCI* Name (English): _____

HCI* Name (Chinese): _____

Address (English): _____

Address (Chinese): _____

District: _____(according to District Administration delineation)

Telephone no.: _____

Service provided: ☐ Pre-procedural Consultation ☐ Colonoscopy Examination ☐ Both

Co-payment fee (with polypectomy)^ (if any): _____

Co-payment fee (without polypectomy)^ (if any): _____

Bank account number#: _____

eHR "Healthcare Institution Identifier (HCI ID)": _____

Charity quota: _____ per month

[*] *Health Care Institution or HCI means the place of practice of the Enrolled CS and the Associated Health Care Provider (if any), which is enrolled in eHRSS and takes part in the Programme.*

[^] *Co-payment fee means the fees not exceeding HK$ 1,000 charged by the Enrolled CS and his Associated Health Care Provider (if any) on the Participant for the subsidised scope of service on top of the Government Subsidy and which will be payable by the Participant to the Enrolled CS at the Health Care Institution where the Colonoscopy Examination is performed. It is advisable that the Co-payment amount be set at HK$0.*

[#] *Each Health Care Institution should specify ONE bank account as per the Authority for Payment to a Bank (Appendix B).*

NOTES:

(a) The name of Applicant, Health Care Institution's name(s), address(es), telephone number(s), Co-payment fee(s) (if any) and charity quota (if any) provided above will be published in the directories of the Programme on the internet and/or in hardcopies for reference by the public.

(b) Please fill in separate Appendix B for each bank account.

(c) When completing and submitting Appendix B, please provide copy of bank correspondence (e.g. bank statement) showing the full name and number of the bank account.

(d) If the bank correspondence relates to an Applicant, the copy must be certified to be a true and complete copy by the Applicant. If the bank correspondence relates to a Health Care Provider, the copy must be certified to be a true and complete copy by the authorised signatory of the Health Care Provider appearing in Appendix B Part 2 – Declaration.

Part II - Undertaking and Declaration

In consideration of the Government of the Hong Kong Special Administrative Region ("**Government**"), as represented by the Director of Health, considering and/or approving this application for enrolment in the Programme, we, the Applicant and the Health Care Provider with particulars as set out in Part I of this Application Form (Appendix A) hereby jointly and severally acknowledge, confirm, undertake, warrant, declare and agree with continuing effect as follows:

(1) we have carefully read and fully understood the terms and conditions set out in the Transaction Documents (including but not limited to this Undertaking and Declaration);

(2) the Applicant is eligible to apply for enrolment in the Programme;

(3) all information and documents provided to the Government in or with this Appendix A and Appendix B and from time to time in relation to the Programme are up-to-date, true, accurate and complete in all respects;

(4) none of us has withheld, and none of us is aware of, any material facts or circumstances that have not been disclosed to the Government which may influence the assessment of this application or the decision of the Government in considering whether or not to approve this application;

(5) this application may not be processed by the Government if any of us fails to provide all information and documents required by the Government;

(6) each of us shall submit to the Government such other information and documents as the Government may require from time to time in relation to this application;

(7) each of us shall inform the Programme Office immediately of any change in any information submitted in relation to this application or if any such information is no longer applicable, true, accurate or complete and of any material change in circumstances affecting the Applicant's eligibility for enrolment or otherwise this application including any incidents of professional misconduct or negligence (substantiated or alleged);

(8) the Applicant is not suspended or prohibited from practising as a registered medical practitioner or registered specialist of Gastroenterology & Hepatology/General Surgery under the Medical Registration Ordinance (Cap.161) ;

(9) until this application is rejected by the Government, or if this application is successful, until the Applicant ceases to be an Enrolled CS, each of us shall comply at all times with all the terms and conditions of the Transaction Documents

(10) the Health Care Provider set out in Part I, Section (D) of this Appendix A is NOT a public sector organisation

(11) the Government, any of its agents or officers (including the Director of Health) and any other persons authorised by the Government shall have full access to and may transfer and use the Applicant's personal data provided in relation to the Programme for the purposes set out in the Statement of Purpose at Part V of this Appendix A. The word "use" shall have the meaning given to it under the Personal Data (Privacy) Ordinance (Cap. 486);

(12) the Applicant hereby gives consent to the Medical Council of Hong Kong to release at

any time the Applicant's personal data to the Director of Health, Government, any agents or officers of the Government and any other person authorised by the Government for the purpose of checking eligibility of the Applicant to enrol in the Programme and, where necessary, for a verification procedure to be carried out for that purpose;

(13) each of us fully understands that non-disclosure or misrepresentation of any information required or provided in connection with this application shall entitle the Government to reject this application;

(14) if any information, undertaking, warranty or declaration given by any of us in this Appendix A is not up-to-date, true, accurate or complete or if any of us fails to comply with any provision of this Undertaking and Declaration, without prejudice to any powers, rights, remedies and claims that the Government may have under this Undertaking and Declaration or in law, the Government shall be entitled to reject this application immediately or immediately cancel the Applicant's enrolment if this application has already been approved;

(15) the authorised signatory(ies) stated in Part IV of this Appendix A is duly authorised by the Health Care Provider to execute this Appendix A for and on behalf of the Health Care Provider and to bind it by his/their signature(s) to the terms and conditions of the Transaction Documents;

(16) this Undertaking and Declaration shall be governed by and construed in accordance with the laws of Hong Kong and each of us shall irrevocably submit to the exclusive jurisdiction of the Courts of Hong Kong; and

(17) the Government retains the ultimate discretion to approve, reject, withhold or cancel any application submitted by a registered medical practitioner.

Part III - Government Disclaimers

(1) Whilst the information provided by the Government in this Application Form (Appendix A), the Authority for Payment to a Bank (Appendix B) and the Definitions, Terms and Conditions of Agreement for Colonoscopy Specialist (Appendix C) (collectively, the "Transaction Documents") has been prepared in good faith, none of them claims to be comprehensive or to have been independently verified. Neither the Government, nor any of its officers, agents or advisors, accepts any liability or responsibility as to, or in relation to, the adequacy, accuracy or completeness of the information contained in this Application Form and other Transaction Documents or any other written or oral information which is, has been or will be provided or made available to any Applicant or Health Care Provider; nor do they make any representation, statement or warranty, express or implied, with respect to such information or to the information on which the Application Form and other Transaction Documents is based. Any liability in respect of any such information or any inaccuracy in the Application Form or omission from the Application Form and other Transaction Documents is expressly disclaimed. Nothing in the Application Form and other Transaction Documents nor in any other written or oral information which is, has been or will be provided or made available to any Applicant should be relied on as a representation, statement or warranty as to the intentions, policy or action in future of the Government, its officers or agents.

(2) Neither the Application Form nor any invitation for submission of applications under the Programme constitutes an offer.

(3) The submission of an application for enrolment by an Applicant shall be taken to be an acceptance of the terms of these disclaimers by the Applicant and the Associated Health Care Provider (if any).

Part IV: Execution

(A) The Applicant

Applicant's signature: _____

Name of Applicant (as shown on Hong Kong Identity Card)

(English): _____ (Chinese): _____

Date: _____

(B) Health Care Provider

Official Stamp

_____

Authorised signature (for and on behalf of the Health Care Provider)

Name in block letters (Authorised signatory): _____

Position of signatory: _____ Date: _____

Email address: _____

Daytime contact telephone number: _____ Fax: _____ (Optional)

Correspondence address[#]: _____

[#] *Please provide documentary proof of correspondence address of the Health Care Provider. Public utility bill or bank statements are accepted as documentary proof.*

I/We, the above Applicant/ the above Applicant and Health Care Provider, agree that by signing this Application Form, a binding Agreement defined in the Definitions section of the Definitions, Terms and Conditions of Agreement for Colonoscopy Specialist (Appendix C) shall be constituted between the Government and me/us on the date on which the Government notifies the Applicant in writing the approval of this application.

Part V – Personal Information Collection Statement

Statement of Purpose

Purposes of Collection

(1) Any information, including the personal data provided to the Government in connection with any application for enrolment in the Programme, will be used by the Government for one or more of the following purposes:
   (a) Processing the application for enrolment in the Programme including but not limited to a verification procedure with data kept by the Medical Council of Hong Kong and the Primary Healthcare Commission under the Health Bureau of the Government;
   (b) Administration, monitoring, auditing and evaluation of the Programme including but not limited to processing subsidy payment, providing necessary health care service and continuity of care to participant, and investigation of incidents and complaints;
   (c) Statistical, programme monitoring, evaluation and research purposes; and
   (d) Any other legitimate purposes as may be required, authorised or permitted by law.

(2) The provision of any information, including the personal data is voluntary. However, if you do not provide sufficient information, we may not be able to process your application.

Classes of Transferees

(3) The personal data you provide are mainly for use within the Government but they may also be disclosed by the Government to other persons, organisations, professional regulatory boards and councils, and third parties for any of the purposes stated in paragraph (1) above, if required.

Access to Personal Data

(4) You have a right to request access to and correction of your personal data under sections 18 and 22 and Data Protection Principle 6, Schedule 1 of the Personal Data (Privacy) Ordinance. A fee may be imposed for complying with a data access request.

Enquiries

Enquiries concerning the personal data provided, including the making of access and correction, should be addressed to the following officer of the Department of Health:

Executive Officer
Programme Office, CRC Screening Programme, Department of Health
19/F, Kwun Tong View, 410 Kwun Tong Road, Kwun Tong, Kowloon
Tel no.: 3565 5665