香港社會醫學學院
HONG KONG COLLEGE OF COMMUNITY MEDICINE
founder College of the Hong Kong Academy of Medicine
Incorporated with litied liability

Application for Professor Lee Shiu Hung Fellowship
Hong Kong College of Community Medicine

I would like to apply for the Hong Kong College of Community Medicine Professor Lee Shiu Hung Fellowship. My particulars are as follows:

Full Name: _____
(as per Identity Document) Surname First Name

Name in Chinese: _____ ID No. _____
(*if applicable*)

Sex: ☐M / ☐F Date of Birth: _____ (dd/mm/yy)

Correspondence Address: _____

_____

Tel. No.: _____ (Office) _____ (Mobile)

Fax No.: _____ E-mail Address: _____

Date of admission to
College Fellowship: _____

Subspecialty: _____

Medical Qualification:

Qualification	Granting Authority	Year Obtained

Working Experience (*including current experience*):

Institution	Post	From	To

If space is insufficient, please attach an appendix page.

Fellowship applied for attending:

Annual Conference / workshops of*:

☐ **Faculty of Public Health**

☐ **The Australasian Faculty of Occupational & Environmental Medicine**

☐ **The Royal Australasian College of Medical Administrators**

Title of Conference / Workshop: _____

Date / Duration: _____

Venue: _____

Purpose: _____

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Anticipated benefits, other details:

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Delete as appropriate

Abstract submitted: Yes / No*

Title of abstract: _____

Summary of abstract: _____

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Abstract accepted by organizer: Yes / No*

Delete as appropriate

Estimated expenditure for attending the Conference:

Registration Fee: _____

All other anticipated expenditure items

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☐ I declare that the particulars given in this application are true and accurate.

☐ I declare that I **have** / **have not** been convicted of an offence punishable by imprisonment (in Hong Kong or elsewhere), and that I **have** / **have not** been found guilty of professional misconduct by the Medical Council of Hong Kong, or any similar regulatory authority outside Hong Kong. (If yes, please provide the relevant documents.)

Signature: _____ Date: _____

Please return the completed form to the Honorary Secretary, HKCCM
c/o Secretariat, Hong Kong College of Community Medicine
Room 908, 9/F, HKAMJC Building, 99 Wong Chuk Hang Road, Aberdeen, HK
(Email: hkccm@hkam.org.hk)

The personal data collected in this application will be used solely for training/examination organized by HKCCM.