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**Application Form for Transition Fellow of**

**the Subspecialty of Interventional Radiology**

Applicants should read the **Appendices I and III of the “Interventional Radiology Subspecialty Training Guidelines”** (subsequently referred to as the “Guidelines”) carefully, and ensure all the essential information is enclosed within this form. Supporting documents should be provided upon request.

**Important Notes to Applicants**

1. Supporting documents for applicants’ training qualifications/procedures performed etc. are not required to be submitted at time of application, but need to made available upon request when needed during the vetting process.
2. Interview may be arranged with the applicant if deemed necessary.
3. Applicants should ensure that all information provided in this application is true, complete and correct to the best of the applicant’s knowledge and belief. Relevant records stated by the applicants are subjected to audit mechanism to ensure its veracity.
4. For unsuccessful cases, the applicant can initiate an appeal to the IR Subspecialty Board within 1 month of notification of results. When appropriate, the applicant may furnish supplementary information and specify the grounds of appeal. The appeal would be reviewed by a Review panel formed by the IR Subspecialty Board and an External Assessor. The decision of the Review panel would be final.

**Application Period**

19th February 2024 to 30th April 2024

Please submit the completed and signed application form by email to: [enquiries@hkcr.org](mailto:enquiries@hkcr.org) **on or before 30th April 2024 at 11:59pm**. **Late submissions would not be considered.**

1. **Personal Particulars**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Name in English: | | Click or tap here to enter text. | | | Click or tap here to enter text. | | |
|  | | (Surname) | | | (First Name) | | |
| Name in Chinese: *(if applicable)* | | | Click or tap here to enter text. | | | | |
| Correspondence Address | | | Click or tap here to enter text. | | | | |
| Email Address: | | | Click or tap here to enter text. | | | | |
| Mobile / Contact number: | | | Click or tap here to enter text. | | | | |
| General Registration No. with MCHK: | | | Click or tap here to enter text. | | | | |
| Specialist Registration No. with MCHK: | | | Click or tap here to enter text. | | | | |
| For HKCR Fellow applicant: | | | | | | | |
| Date of Passing Exit Assessment of HKCR  (Month/Year): | | | | Click or tap here to enter text. | | | | |
| ***(For applicant who successfully passed his/her Exit Assessment in or***  ***after January 2020 only)***  Completion of 6 months of Vascular and Interventional Radiology  during Higher Subspecialty Training (Y/N): | | | | | | | Click or tap here to enter text. |
| HKAM Fellowship No.: | | | | Click or tap here to enter text. | | | | |
| For Certification for Specialist Registration (CSR) applicant: | | | | | | | |
| Non-local Specialist Registration as Specialist in Radiology | | | | | | | |
| Awarding Institution: | Click or tap here to enter text. | | | | | | |
| Date of Award:  *(dd/mm/yyyy)* | Click or tap here to enter text. | | | | | | |
| Date of Commencement of Radiology Practice in Hong Kong:  *(dd/mm/yyyy)* | | | | | | Click or tap here to enter text. | |

1. **Relevant Professional Qualifications/Training and Experience**

Please provide a brief CV or summary in the following box (additional document can be appended as attachment) to illustrate your relevant professional qualifications/training and experience in the field of Interventional Radiology.

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| Click or tap here to enter text. |

1. **Procedures performed**

According to the Guidelines, the applicant must have satisfied the College that he/she had **at least four years of proven good practice** (24 months supervised training equivalent) in Interventional Radiology, during which he/she must have performed or endorsed **at least 360 Tier B procedures**. The standard of such practice or supervision must be assessed as satisfactory by the College for the purpose of accreditation.

Please list out relevant Tier B procedures using the following format and append as an Excel attachment.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No. | Date  *(dd/mm/yyyy)* | Detail of Patient | | | | Hospital | Procedure performed | Remarks (e.g. procedure-related complications) |
| Age | Sex | HKID (First four alpha-numeric digits) | HN no. / Hospital record no. |
|  | 01/01/2023 | 18 | M | A123 | HN1234567A | ABC  Hospital | Trans-arterial chemoembolization of liver tumour | N/A |

1. **Declaration**

I, the undersigned, declare that all information provided in this application form is true, complete, and correct to the best of my knowledge and belief.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Applicant’s Signature: |  | | Date: | Click or tap here to enter text. | |
|  |  | |  | |  |
| Note: A HKCR Fellow is required to countersign and certify to his/her best knowledge that all information provided by the applicant is true, complete, and correct to the applicant’s best knowledge and belief, as below: | | | | | |
|  | | | | | |
| Certifier’s Signature: |  | | Date: | Click or tap here to enter text. | |
|  |  | |  |  | |
| Certified by  (Name in Full): | Click or tap here to enter text. | | Click or tap here to enter text. | | |
|  | (Surname) | | (First Name) | | |
| Certifier’s MCHK Registration Number: | | Click or tap here to enter text. | | | |