THE COLLEGE OF DENTAL SURGEONS OF HONG KONG
香 港 牙 科 醫 學 院

SAMPLE

Basic Trainee Application Form

Photo

Reference No.: _____ This number will be assigned later.

Specialty: Periodontology — Please specify the specialty you are applying for.

Part 1

#Name: Chan Yee Man #Name in Chinese: 陳二文

Nationality: Chinese Sex: *M / F Date of Birth: 1/1/1991

*HKID Card/Passport No.: K123456(1)

Address: Room 123, Grand Tower, 505 Nathan Road, Kowloon

Address for Correspondence *(if different from above)*:

ditto

Tel No.: (Home) 22334455 (Office) 24681013

Mobile No.: 6000 2222 Fax No.: 24681012

E-mail Address: chan2man@netvigator.com

Dental Council of Hong Kong Dentists Registration No.: D04321 Year 2014

 # Identical with HKID Card/Passport No. ** Please delete as appropriate*

For Official Use

❒ Recognised Duration of Training to receipt date of application: _____ years _____ months

❒ Recommended to College Council for approval
Year & Month of Commencement of Recognised Basic Training: _____
MM / YYYY

❒ Not recommended to College Council for approval

Comments: _____

_____

_____ _____

Signature Signature

Name: _____ Name: _____

Chairman of Specialty Board Secretary of Specialty Board

Date: _____ Date: _____

Please specify the specialty you are applying for.

Part 2 ***CDSHK Basic Trainee Application Form***

Reference No.: _____ Specialty: Periodontology

Qualification(s)	**Institution**	**Date of Award** **DD/MM/YYYY**
BDS	The University of Hong Kong	05/12/2014

Details of Training

Training Centre	**Post**	**From M/Y**	**To M/Y**	**Duration (No. of years & months; full time equivalent)**	**For Official Use Accredited Duration (years & months)**
Faculty of Dentistry, University of Hong Kong	Junior Hospital Dental Officer	8/2014	8/2015	1 year	
Faculty of Dentistry, University of Hong Kong	MDS Student	10/2015	12/2015	3 months	
Total Number of Years and Months in Training:				1 year 3 months	

Please specify the up-to-date (upon the month of your application) training programme in which you have enrolled.

Recommended by

Please request for a signature to indicate that the Supervisor of the Training Centre will undertake supervision of your training.

_____ _____

Signature Signature

_____ _____

Name of Applicant Name of Supervisor of Training Centre

Date: _____ Date: _____

CHECKLIST *[Please tick and enclose the original/true copies (certified by a CDSHK Fellow) of the following items.]*

- ☐ HKID Card/Passport (destroy upon verification);
- ☐ supporting evidence of securing Basic Training attachment from accredited training centre;
- ☐ supporting evidence for CME/CPD records for Year 1, as required by the Specialty Board concerned;
- ☐ certificate(s) of the qualification(s) listed in Part 2;
- ☐ Certificate of Registration issued by the Dental Council of Hong Kong;
- ☐ documented evidence of your training; and
- ☐ a non-refundable processing fee of HK$500, cheque made payable to "The College of Dental Surgeons of Hong Kong"

Kindly send the above to The Secretariat, The College of Dental Surgeons of Hong Kong, Room 902, 9/F, HKAM Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong.

The personal data provided will be used by the College of Dental Surgeons of Hong Kong for training and communication purpose.