Appendix A

APPLICATION FORM

Application by Health Care Provider for Enrolment in the Health Care Voucher Scheme, Vaccination Subsidy Scheme, Residential Care Home Vaccination Programme and Primary Care Directory (“Scheme/Programme”)

Enrolment Reference No.:_______________ (Official Use Only)

Application for enrolment by a health care provider to the Scheme/Programme is subject to Government’s consideration of all the circumstances and factors as Government thinks fit which include but are not limited to the conduct, integrity, reputation, management and past and recent performance of the health care provider. In any event, acceptance of enrolment of a health care provider in the Scheme/Programme is at the absolute discretion of the Government.

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

Part I – Scheme(s)/Programme to which this application relates and Interpretation

I, the person whose particulars appear in Section (A) of Part II below (“Applicant”), hereby apply to the Government to enrol in the following scheme(s)/programme –

☐ Health Care Voucher Scheme (“HCVS”)

☐ Vaccination Subsidy Scheme (“VSS”)

☐ Residential Care Home Vaccination Programme (“RVP”)

☐ Primary Care Directory (“PCD”)

The definitions and rules of interpretation set out in the Definitions at Appendices C, F, J and K with respect to the relevant scheme(s)/programme as specified by the Applicant in this Part shall apply to this Application Form.

Part II – Application and Particulars of the Applicant and Medical Organization

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

(A) Personal particulars

Name (as shown on Hong Kong Identity Card)
(in English):____________________________________
(in Chinese):____________________________________

Hong Kong Identity Card No.:_____________________________
Daytime contact tel no.#:_________________________________
Contact e-mail address:_________________(Please provide one e-mail address only)
Fax no.#:____
Correspondence address#:____
____

(Please provide documentary proof of correspondence address such as public utility bill or bank statement.)
 # If Applicant solely applies for enrolment in the Primary Care Directory, the provision of such information is not mandatory.

(B) Particulars of profession

I am practising as: (Please tick one box ONLY and provide a copy of the relevant valid practising certificate (except in the case of a registration under section 85 of the Chinese Medicine Ordinance (Cap. 549)). For the Professional Registration Number, it refers to the number assigned by relevant professional body or council to the Applicant upon registration with that body or council.)

For application for enrolment in HCVS, VSS, RVP or PCD by medical practitioners –

☐ 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:_________________)

For application for enrolment in HCVS or PCD –

☐ a registered dentist (within the meaning of the Dentists Registration Ordinance, Cap. 156)) who holds a valid practising certificate issued under the Ordinance (Professional Registration Number:__________________)

☐ a registered Chinese medicine practitioner (within the meaning of the Chinese Medicine Ordinance (Cap. 549)) who either:
(i) holds a valid practising certificate issued under the Ordinance (Professional Registration Number:__________________) ; or
(ii) is registered under section 85 of that Ordinance (Professional Registration Number:__________________).

For application for enrolment in HCVS only –

☐ a registered chiropractor (within the meaning of the Chiropractors Registration Ordinance (Cap. 428)) who holds a valid practising certificate issued under the Ordinance (Professional Registration Number:__________________)

☐ a registered nurse (within the meaning of the Nurses Registration Ordinance (Cap. 164)) who holds a valid practising certificate issued under the Ordinance (Professional Registration Number:__________________)

☐ an enrolled nurse (within the meaning of the Nurses Registration Ordinance (Cap. 164)) who holds a valid practising certificate issued under the Ordinance (Professional Registration Number:)

☐ a medical laboratory technologist registered under the Supplementary Medical Professions Ordinance (Cap. 359) ("SMPO") who holds a valid practising certificate issued under the SMPO (Professional Registration Number:_____ ______________)

☐ an occupational therapist registered under the SMPO who holds a valid practising certificate issued under the SMPO (Professional Registration Number: __________________)

☐ a physiotherapist registered under the SMPO who holds a valid practising certificate issued under the SMPO (Professional Registration Number:_____ __________________)

☐ a radiographer registered under the SMPO who holds a valid practising certificate issued under the SMPO (Professional Registration Number:____________________)

☐ an optometrist registered under the SMPO (in Part I of the register) who holds a valid practising certificate issued under the SMPO (Professional Registration Number:_________________)

*in my own name/*under the name of or for the Medical Organization set out in Section (C).

* *delete as appropriate*

(C) The Medical Organization [This section and Section (D) below is not required when applying for enrolment in PCD only. The meaning of "Medical Organization" can be found in the Definitions at Appendices C, J and K with respect to the relevant scheme(s) as specified by the Applicant in Part I above.]

Name of Medical Organization:
(in English):____________________________
(in Chinese):____________________________

Business Registration Number:____________________

Daytime contact tel no.:__________________________
Contact e-mail address:__________________________
Fax no.:_______________________________________
Correspondence address:____
____

(Please provide documentary proof of correspondence address such as public utility bill or bank statement.)

(D) Relationship between parties (Please select one of the following items)

The relationship between me and the Medical Organization is:

☐ sole proprietor of the Medical Organization

☐ partner of the Medical Organization

☐ shareholder of the Medical Organization

☐ director of the Medical Organization

☐ employee of the Medical Organization

☐ others (please specify) _____________________________________

(E) Place of practice and service fee

The schemes/programmes to be enrolled under the profession under Section (B), practice name, address, telephone number and service fees are:

(Note : If you would provide outreaching vaccination services at non-clinic settings, please provide the relevant information under Practice No. 5.)

Practice No. (1) : (Please provide a copy of the documentary proof for address of the practice, such as public utility bill or bank statement.)

Name (in English):______________________________

Name (in Chinese):______________________________

Address (in English):______________________________

Address (in Chinese):______________________________

District:______________________________

Telephone no.:______________________________

Scheme(s)/Programme to which this Application relates:

☐ HCVS ☐ VSS ☐ RVP ☐ PCD

For application for enrolment in PCD only:

Type of practice (Choose one for each place of practice):

☐ Non-governmental Organization ☐ Private ☐ University

Service fee per vaccination# at the above practice:

Eligible Person /Vaccine	Pregnant women	Person aged 65 or above	Person aged 6 months to less than 12 years old	Person with Intellectual Disability	Person Receiving Disability Allowance
SI (QIV)*					
SI(TIV)*					
23vPPV	N/A		N/A	N/A	N/A

SI (QIV)* Quadrivalent Influenza Vaccine

SI (TIV)* Trivalent Influenza Vaccine

Practice No. (2): (Please provide a copy of the documentary proof for address of the practice, such as public utility bill or bank statement.)

Name (in English):____

Name (in Chinese):____

Address (in English):____

Address (in Chinese):____

District:____

Telephone no.:____

Scheme(s)/Programme to which this Application relates:
☐ HCVS ☐ VSS ☐ RVP ☐ PCD
For application for enrolment in PCD only:
Type of practice (Choose one for each place of practice):
☐ Non-governmental Organization ☐ Private ☐ University

Service fee per vaccination# at the above practice:

Eligible Person /Vaccine	Pregnant women	Person aged 65 or above	Person aged 6 months to less than 12 years old	Person with Intellectual Disability	Person Receiving Disability Allowance
SI (QIV)*					
SI(TIV)*					
23vPPV	N/A		N/A	N/A	N/A

SI (QIV)* Quadrivalent Influenza Vaccine
SI (TIV)* Trivalent Influenza Vaccine

Practice No. (3): (Please provide a copy of the documentary proof for address of the practice, such as public utility bill or bank statement.)

Name (in English):____

Name (in Chinese):____

Address (in English):____

Address (in Chinese):____

District:____

Telephone no.:____

Scheme(s)/Programme to which this Application relates:
☐ HCVS ☐ VSS ☐ RVP ☐ PCD

For application for enrolment in PCD only:
Type of practice (Choose one for each place of practice):
☐ Non-governmental Organization ☐ Private ☐ University

Service fee per vaccination# at the above practice:

Eligible Person /Vaccine	Pregnant women	Person aged 65 or above	Person aged 6 months to less than 12 years old	Person with Intellectual Disability	Person Receiving Disability Allowance
SI (QIV)*					
SI(TIV)*					
23vPPV	N/A		N/A	N/A	N/A

SI (QIV)* Quadrivalent Influenza Vaccine
SI (TIV)* Trivalent Influenza Vaccine

Practice No. (4): (Please provide a copy of the documentary proof for address of the practice, such as public utility bill or bank statement.)

Name (in English):____

Name (in Chinese):____

Address (in English):____

Address (in Chinese):____

District:____

Telephone no.:____

Scheme(s)/Programme to which this Application relates:

☐ HCVS ☐ VSS ☐ RVP ☐ PCD

For application for enrolment in PCD only:

Type of practice (Choose one for each place of practice):

☐ Non-governmental Organization ☐ Private ☐ University

Service fee per vaccination# at the above practice:

Eligible Person /Vaccine	Pregnant women	Person aged 65 or above	Person aged 6 months to less than 12 years old	Person with Intellectual Disability	Person Receiving Disability Allowance
SI (QIV)*					
SI(TIV)*					
23vPPV	N/A		N/A	N/A	N/A

SI (QIV)* Quadrivalent Influenza Vaccine

SI (TIV)* Trivalent Influenza Vaccine

Practice No. (5): (only applicable to outreaching vaccination at non-clinic setting under VSS)

(5) Name (in English):____

Name (in Chinese):____

Address (in English):____

Address (in Chinese):____

District:____

Telephone no.:____

Service fee per vaccination # at non-clinic setting:

Eligible Person /Vaccine	Pregnant women	Person aged 65 or above	Person aged 6 months to less than 12 years old	Person with Intellectual Disability	Person Receiving Disability Allowance
SI (QIV)*					
SI(TIV)*					
23vPPV	N/A		N/A	N/A	N/A

SI (QIV)* Quadrivalent Influenza Vaccine
SI (TIV)* Trivalent Influenza Vaccine

The service fee is the fee (exclusive of Government subsidy) for one vaccination charged by the Applicant or the Medical Organization. It shall be a specific fee.

*The service fee for seasonal influenza vaccination is only for inactivated influenza vaccine given intramuscularly. Only the service fee for vaccination using QIV will be displayed at the Online Service Directory of the Department of Health.

With respect to the relevant scheme(s)/programme the enrolment in which is being applied for, the name of applicant, practice's name(s), address(es), telephone number(s), and service fee (if applicable) provided above will be published in the directories of the HCVS, VSS, RVP and PCD and/or other Government programmes to promote primary care, as appropriate on the internet or in hardcopies for reference by the public. For

enrolment in PCD, your Professional Registration Number and type(s) of practice will also be displayed in the PCD.

Part III - Undertaking and Declaration

HCVS, VSS and RVP

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 relevant scheme(s) as specified by the Applicant in Part I of this form, the Applicant and the Medical Organization hereby jointly and severally acknowledge, confirm, undertake, warrant, declare and agree with continuing effect as follows:

(a) we have carefully read and fully understood the Application Form and all other relevant Transaction Documents with respect to the relevant scheme(s) as specified by the Applicant in Part I of this form;

(b) the Applicant is eligible to apply for enrolment in the scheme(s) as specified by the Applicant in Part I of this form according to the Covering Notes for Application by Health Care Provider for Enrolment in the Health Care Voucher Scheme, Vaccination Subsidy Scheme, Residential Care Home Vaccination Programme and Primary Care Directory (“Covering Notes”);

(c) all information and documents provided to the Government in or with this Application Form and from time to time in relation to the scheme(s) as specified by the Applicant in Part I of this form (whether in any of our own hands or not) are up-to-date, true, accurate and complete in all respects;

(d) 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;

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

(f) 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;

(g) each of us shall inform in writing the Vaccination Office, Department of Health of the Government (i) 2 working days before raising the service fee as specified in Part II, Section (E) of the Application Form and (ii) 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 in the scheme(s) as specified by the Applicant in Part I of this form or otherwise this application including any incidents of professional misconduct or negligence (substantiated or alleged);

(h) the Medical Organization set out in Section (C) of Part II of this Application Form is a private sector organization or a non-government organisation;

(i) the Applicant is not suspended or prohibited from practising in the profession indicated by the Applicant in Section (B) of Part II of this Application Form;

(j) until this application is rejected by the Government or, if this application is successful, until the Applicant ceases to be an Enrolled Health Care Provider, each of us shall comply at all times with all the terms and conditions of this Application Form and the other relevant Transaction Documents with respect to the relevant scheme(s) as specified by the Applicant in Part I of this form;

(k) the Government, any of its agents or officers (including the Director of Health) and any other persons authorized by the Government shall have full access to and may transfer and use the Applicant's personal data provided in relation to the scheme(s) for the purposes set out in the Statement of Purpose with respect to the relevant scheme(s) as specified by the Applicant in Part I of this form, and the word "use" shall have the meaning given to it under the Personal Data (Privacy) Ordinance, Cap. 486;

(l) the Applicant hereby gives consent for each of the following professional regulatory board and council to release at any time the Applicant's personal data held by any of them to the Director of Health, Government, any agents or officers of the Government and any other person authorized by the Government for the purpose of processing this application and, where necessary, for a verification procedure by electronic means to be carried out for that purpose:

  (a) Medical Council of Hong Kong;
  (b) Dental Council of Hong Kong;
  (c) Chinese Medicine Council of Hong Kong;
  (d) Chiropractors Council of Hong Kong;

(e) Nursing Council of Hong Kong;
(f) Physiotherapists Board of Hong Kong;
(g) Occupational Therapists Board of Hong Kong;
(h) Medical Laboratory Technologists Board of Hong Kong;
(i) Radiographers Board of Hong Kong; and
(j) Optometrists Board of Hong Kong

(m) 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;

(n) if any information, undertaking, warranty or declaration given by any of us in this Application Form 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, this application shall be rejected immediately and if this application has already been approved, the approval for the Applicant's enrolment in the relevant scheme(s) as specified by the Applicant in Part I of this form shall be revoked immediately ;

(o) the Authorized Signatory(ies) stated in Section (B) of Part V is duly authorized by the Medical Organization to execute this Application Form for and on behalf of the Medical Organization and to bind it by his/their signatures(s) to the terms and conditions of this Application Form and all other relevant Transaction Documents with respect to the relevant scheme(s) as specified by the Applicant in Part I of this form; and

(p) this Undertaking and Declaration shall be governed by and construed in accordance with the laws of the Hong Kong Special Administrative Region of the People's Republic of China ("Hong Kong") and each of us shall irrevocably submit to the exclusive jurisdiction of the Courts of Hong Kong.

PCD

The Applicant has carefully read and fully understood the Disclaimer and Terms and Conditions and all other relevant documents with respect to the PCD as set out in Appendix F.

Part IV – Government Disclaimers

1. Whilst the information provided by the Government in this Application Form and the Covering Notes have 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, the Covering Notes or any other written or oral information which is, has been or will be provided or made available to any Applicant or Medical Organization (if applicable); 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 or the Covering Notes are based. Any liability in respect of any such information or any inaccuracy in the Application Form or the Covering Notes or omission from the Application Form or the Covering Notes is expressly disclaimed. Nothing in the Application Form, the Covering Notes 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 Covering Notes nor any invitation for submission of applications under the scheme(s)/programme as specified in Part I of this form shall constitute an offer.

3. The submission of an application for enrolment by an Applicant shall be taken to be an acceptance of the terms of this disclaimer by the Applicant and the Medical Organization (if applicable).

Part V – Execution

(A) The Applicant

Applicant's signature: ______________________

Name of Applicant as shown on Hong Kong Identity Card:

(in English): ______________________

(in Chinese): ______________________

Date: ______________________

(B) The Medical Organization (should be completed for enrolment in HCVS, RVP and/or VSS)

Official Stamp   .... Authorized signature For and on behalf of the company/organization

Name in block letters (Authorized Signatory): ______________________

Position: ______________________

Name of company/organization: ______________________

Date: ______________________

I/We, the above Applicant/ the above Applicant and Medical Organization, have read and agree to the contents in Parts I to IV of this application form and solemnly repeat each and every statement set out in the Undertaking and Declaration as set out in Part III of this application form. I/We also declare that the information given by me/us in this application form is up-to-date, true, accurate and complete in all respects.

I/We also agree that by signing this Application Form, a binding agreement in the terms and conditions set out in Appendices C, F, J and K with respect to the scheme(s)/programme the enrolment in which is being applied for as indicated in Part I hereof 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.

Statement of Purpose

Purposes of Collection

1. The personal data provided will be used by the Department of Health for one or more of the following purposes:
   - (a) processing the application for enrolment in the scheme(s)/programme as specified in Part I of this form, payment by the Government, and the administration and monitoring of the scheme(s) as specified in Part I of this form;
   - (b) Government programmes to promote primary care;
   - (c) for statistical and research purposes; and
   - (d) any other legitimate purposes as may be required, authorized or permitted by law.

2. The provision of personal data in the application form is voluntary. 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 Department of Health but they may also be disclosed to other Government bureaux and departments, respective professional regulatory boards and councils and other organizations for the purpose stated in paragraph 1 above, if required.

Access to Personal Data

4. You have a right to request access to and to request the 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

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

For medical practitioners,

Executive Officer, Vaccination Office
2/F, 147C Argyle Street
Kowloon
Telephone No.: 2125 2125

For healthcare service providers in other professions,

Executive Officer, Health Care Voucher Unit
1/F, Central District Health Centre
1 Kau U Fong, Central, Hong Kong
Telephone No.: 3582 4102