

For Requests Relating to HCVS ONLY

To: Health Care Voucher Division
 Fax: 3582 4115 or email: hcvd@dh.gov.hk

For Requests Relating to VSS / COVID-19 Clinics/Non-clinic settings / RVP and HCVS (if any)

To: Programme Management and Vaccination Division
 Fax: 2713 9576 or email: vacs@dh.gov.hk

Request to Change Particulars

Enrolled Health Care Provider (EHCP) under the Health Care Voucher Scheme, Vaccination Subsidy Scheme, COVID-19 Vaccination Programme at Clinics/Non-clinic settings and/or Residential Care Home Vaccination Programme

(Read "Notes for Attention" before completing this form)

Legend:	HCVS:	Health Care Voucher Scheme	LAIV:	Live-attenuated influenza vaccine
	VSS:	Vaccination Subsidy Scheme	QIV:	Quadrivalent influenza vaccine
	RVP:	Residential Care Home Vaccination Programme	PCV13:	13-valent pneumococcal conjugate vaccine
	PCD:	Primary Care Directory	PCV15:	15-valent pneumococcal conjugate vaccine
	DA:	Disability Allowance	23vPPV:	23-valent pneumococcal polysaccharide vaccine
	CSSA:	Comprehensive Social Security Assistance Scheme of the Social Welfare Department		
	COVID-19:	COVID-19 Vaccination Programme		

Present Particulars of EHCP

Name of EHCP	:	_____
EHCP HKIC No.	:	_____ (SPID No.: _____)
Name of Medical Organisation	:	_____

Change Requests - Complete only RELEVANT parts
(Please put a "✓" in the appropriate box(es))

(A) Personal Particulars of EHCP:

<input type="checkbox"/>	Correspondence address	:	_____
	(in English)		_____
	(in Chinese)	:	_____
<input type="checkbox"/>	Contact email address	:	_____
<input type="checkbox"/>	Daytime contact tel. no.	:	_____
<input type="checkbox"/>	fax no.	:	_____

(B) Particulars of Medical Organisation:

<input type="checkbox"/>	Correspondence address	:	_____
	(in English)		_____
	(in Chinese)	:	_____
<input type="checkbox"/>	Contact email address	:	_____
<input type="checkbox"/>	Daytime contact tel. no.	:	_____
<input type="checkbox"/>	fax no.	:	_____

(C) Practice Details:

<input type="checkbox"/>	<u>REMOVE</u> an enrolled practice from EHCP's enrolment
	Practice name (in English) : _____
	(in Chinese) : _____
	Practice address (in English) : _____
	(in Chinese) : _____

REMOVE an enrolled practice from EHCP's enrolment (Continue)

Reasons for removal [Optional] : _____

Scheme(s)/ Programme(s) to which this removed practice relates:

HCVS VSS RVP PCD COVID-19 (Clinics / Non-clinic settings)

(C) Practice Details:

ADD a new practice under EHCP's enrolment

[N.B. If a new bank account is nominated, please complete an "[Authority for Payment to a Bank](#)" (**Appendix B**) and submit the required documentary proofs **by post**.]

Practice name (in English) : _____

(in Chinese) : _____

Practice address (in English) : _____

(in Chinese) : _____

Practice tel. no. : _____

Please deliver the Smart IC Card Reader to the new practice via post.

Scheme(s)/ Programme(s) to which this new practice relates[^]:

HCVS VSS (**Clinic setting / Non-clinic setting** ^{##})

RVP PCD (**Non-governmental Organisation / Private / University** ^{##})

[^] Only applicable to registered scheme(s)/ programme(s) ^{##} Please circle as appropriate.

Scheme(s)/ Programme(s) to which this new practice relates:

COVID-19 (Clinics / Non-clinic settings) ^{**}

Age groups which Covid-19 vaccination will be provided to

(Children aged 6 months to less than 12 Persons aged 12 or above)

^{**} by signing this Request to Change Particulars, the Applicant and Medical Organization understand and agree that a binding agreement on the terms and conditions set out with respect to the COVID-19 Vaccination Programme shall be constituted between the Government and the Applicant and Medical Organization.

VSS Service Fees Schedule (For new practice relevant to VSS)

[N.B. Service fees include **ALL** fees related to the vaccination but **EXCLUSIVE** of Government subsidy; and The service fees information for use of QIV will be displayed in the [on-line directory of the CHP website](#).]

<input type="checkbox"/> Pregnant Women	QIV	\$		
<input type="checkbox"/> Children and adolescents (Aged 6 months to under 18 years)	QIV	\$	LAIV	\$
<input type="checkbox"/> Persons aged 50 - 64	QIV	\$		
<input type="checkbox"/> Elderly aged ≥ 65	QIV	\$	23vPPV	\$
	PCV13	\$	PCV15	\$
<input type="checkbox"/> Persons with intellectual disability (PID)	QIV	\$	LAIV	\$
<input type="checkbox"/> Recipients of Disability Allowance / standard rate of "100% disabled" or "requiring constant attendance" under CSSA	QIV	\$	LAIV	\$

(D) Bank Details:

CHANGE in bank details of currently enrolled practices

[N.B. To be supported by a completed "[Authority for Payment to a Bank](#)" (**Appendix B**) and submit the required documentary proofs **by post**.]

(E) Withdrawal:

WITHDRAW from : HCVS VSS RVP PCD
 COVID-19 (Clinics / Non-clinic settings)

Reasons [Optional] : Resignation Retirement Others: _____

Signature of EHCP

Official Stamp and Authorised Signature
For and on behalf of the Medical Organisation

Name in Block Letters

Name in Block Letters

Date : _____

Date: _____

Notes for Attention

1. This change form DOES NOT apply to changes of EHCP's name, HKIC No., profession, medical organisation or Scheme(s)/ Programme enrolment. Such changes should be made in a new enrolment application. (For details, please visit Elderly Health Care Voucher Scheme website www.hcv.gov.hk or Centre for Health Protection website www.chp.gov.hk.)
2. Please attach documentary proofs such as public utility bill, bank statement or valid Business Registration Certificate where applicable.
3. The name of EHCP, practice address and phone number and net service fees under VSS (except the service fee of LAIV) will be displayed in the *List of Enrolled Healthcare Service Providers* at the website of the CHP and HCVS.
4. As applicable, please mail/ fax/ email the completed form together with a copy of Hong Kong Identity Card and the related supporting documents (such as documentary proof of correspondence address) to the respective office of the Department of Health:

Programme Management and Vaccination Division (for requests relating to VSS / COVID-19 Clinics/Non-clinic settings / RVP and HCVS (if any))

Address: 3/F, Two Harbourfront, 18-22 Tak Fung Street, Hung Hom, Kowloon

Fax: 2713 9576 Email: vacs@dh.gov.hk

Health Care Voucher Division (for requests relating to HCVS only)

Address: Suites 901-4, 9/F, AXA Tower, Landmark East, 100 How Ming Street, Kwun Tong, Kowloon

Fax: 3582 4115 Email: hcvd@dh.gov.hk

Please note that all documentary proofs will not be returned.

Statement of Purpose

Purposes of Collection

1. The personal data provided will be used by the Department of Health (in relation to HCVS, VSS, COVID-19 Clinics/Non-clinic settings and/or RVP) and/or Health Bureau (in relation to PCD) for one or more of the following purposes:
 - (a) processing of payment, and the administration and monitoring of the concerned Scheme(s)/ Programme;
 - (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 change form is voluntary. If you do not provide sufficient information, the Government may not be able to update the change of your particulars in relation to your enrollment.

Classes of Transferees

3. The personal data you provide are mainly for use within the Department of Health (in relation to HCVS, VSS, COVID-19 Clinics/Non-clinic settings and/or RVP) and/or Health Bureau (in relation to PCD) but they may also be disclosed to other Government bureaux and departments, respective professional regulatory board and council, respective healthcare professional bodies accredited under the Accredited Registers Scheme for Healthcare Professions of the Government and other organisations 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:

Executive Officer (Vaccination Subsidy Scheme)

Programme Management and Vaccination Division, Department of Health

3/F, Two Harbourfront, 18-22 Tak Fung Street, Hung Hom, Kowloon

Tel. no.: 2125 2299

Fax: 2713 9576

Email: vacs@dh.gov.hk

Executive Officer, Health Care Voucher Division

Health Care Voucher Division, Department of Health

Address: Suites 901-4, 9/F, AXA Tower, Landmark East, 100 How Ming Street, Kwun Tong, Kowloon

Tel. no.: 3582 4102

Fax: 3582 4115

Email: hcvd@dh.gov.hk

Executive Officer (Primary Healthcare Office) 1A

Primary Healthcare Office, Health Bureau, The Government of the Hong Kong Special Administrative Region

Address: 11/F, The HUB, 23 Yip Kan Street, Wong Chuk Hang, Hong Kong

Tel. no.: 2205 1855

Fax: 2556 2638

Email: pho@healthbureau.gov.hk

Application by Health Care Provider for Enrolment in the Vaccination Subsidy Scheme (VSS)

Record of the Vaccine Storage Refrigerator

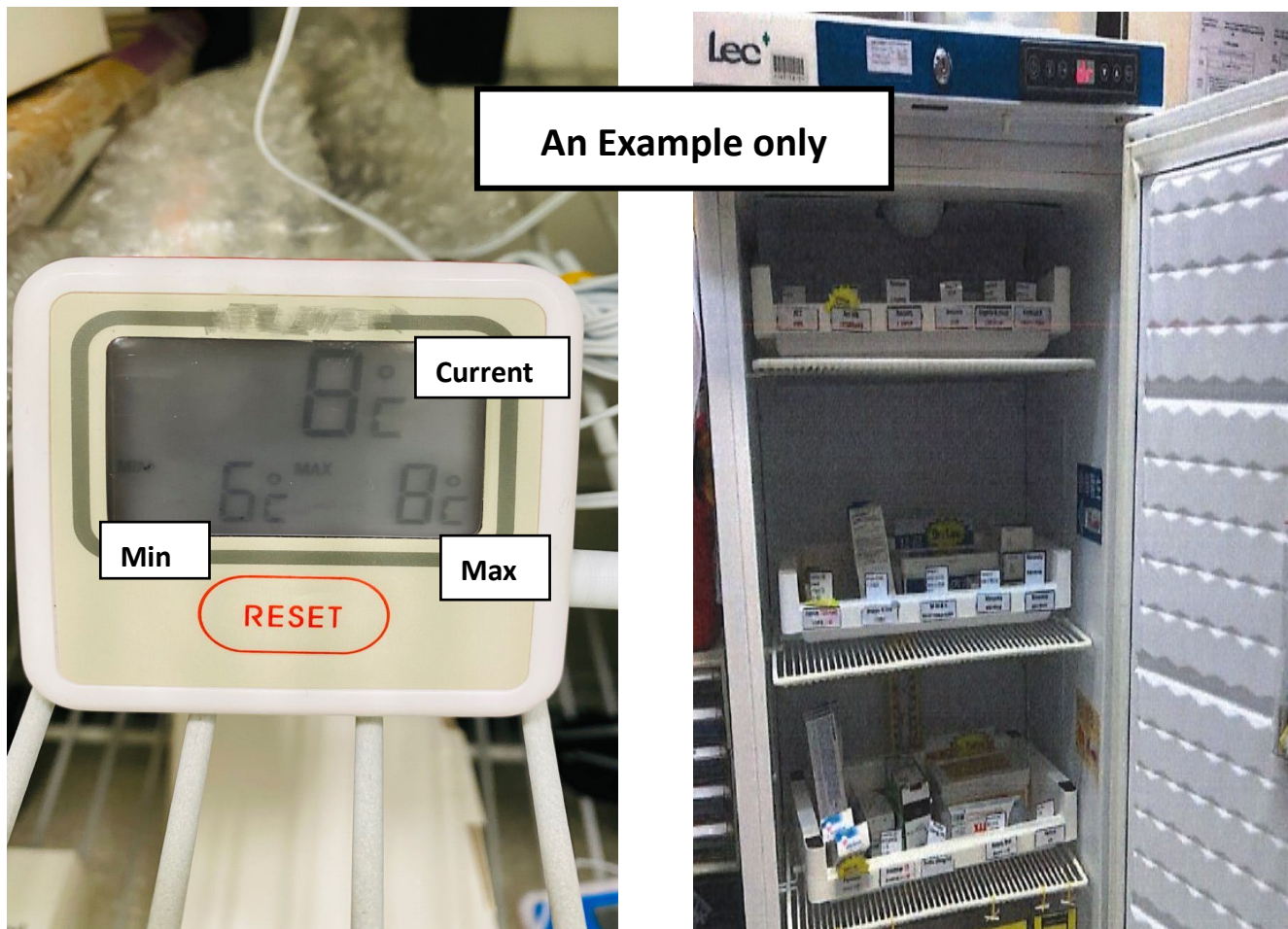
Starting from 2023/24 season, doctors enrolled in VSS have to use Purpose-built vaccine refrigerators (PBVR) for vaccine storage. For further details regarding vaccine storage under VSS, please refer to Chapter 6 of the VSS Doctor's Guide – Requirements on vaccine storage and handling under VSS (https://www.chp.gov.hk/files/pdf/vssdg_ch6_vaccine_storage_and_handling.pdf).

For record and follow-up purpose, please complete this form, supplemented with:-

- (1) One photo of the interior of the refrigerator **currently** used for vaccine storage at your clinic; and
- (2) One photo of the temperature monitoring device AND temperature record

Should you have any enquiries **regarding PBVR**, please contact Ms. TAM at 3975 4848 or Ms. CHAN at 3975 4846. For **other VSS matters**, please contact our staff at 2125 2299 or 3975 4806

(1) Photo of the interior of the refrigerator and Max-min thermometer



Fridge Brand Name: _____

Doctor's Name: _____

SPID: _____

Signature: _____

Fridge Model No.: _____

Practice Name and No.: _____

Contact Phone number: _____

Date: _____

