



Hong Kong Association of Family Medicine And Primary Health Care Nurses Limited

香港家庭醫學及基層健康護士協會有限公司

Website: <http://www.hkfmphcn.com/>

Membership Application Form

(All information collected will be treated with strict confidentiality.)

For Official Use Only	Membership No:	Membership Fee: HK\$ 100
	Receipt No.: Receipt sent on:	Membership card sent on:
	Data base entered on: by:	Remarks:

Please complete the form in English (except the Chinese name if any) and in **BLOCK LETTERS**.

<p>*Name in English (BLOCK LETTERS)</p> <p>Surname: Other names:</p>	<p>Identification Documents</p> <p>* First 4 digits of HKID / passport no.:</p>
--	--

<p>*Name in Chinese:</p>	<p>*Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p>Title: <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr <input type="checkbox"/> Prof</p>
---------------------------------	--

***Correspondence Address:**

<p>Telephone No. Office:</p> <p style="padding-left: 20px;">Home:</p>	<p>*Mobile:</p>	<p>*E-mail:</p>
---	------------------------	------------------------

<p>Occupation /Job Title:</p>	<p>Place of work:</p>
--------------------------------------	------------------------------

Education	Professional Qualification: (e.g. EN, RN, NS)
	Other Academic Qualification: (e.g. BSc, MBA, PhD)

Membership Type	<input type="checkbox"/> Full members: Any registered nurse/ enrolled nurse who has recognized primary health care training or whose working area involves in any kind of primary health care practice <input type="checkbox"/> Associated members: Any registered nurse/ enrolled nurse who is interested in Primary Health Care Nursing <input type="checkbox"/> Affiliated members: Any personnel who is interested in primary health care practice <input type="checkbox"/> Renewal of membership Membership No: _____
------------------------	---

Please indicate which of the College committees and/or activities you are interested in contributing as a voluntary member.

- | | | |
|---|--|--|
| <input type="checkbox"/> Public Affair & membership | <input type="checkbox"/> Education committee | <input type="checkbox"/> Programme committee |
| <input type="checkbox"/> Executive/secretariat | <input type="checkbox"/> Conference activities | |
| <input type="checkbox"/> others (specify): | | |

I understand and accept that the personal information I have provided to the Hong Kong Association of Family Medicine and Primary Healthcare Nurses Limited will be used for membership approval and activities of the Association.

I declare the information given in this application is, to the best of my knowledge, accurate and complete. I understand that any false or misleading information will lead to disqualification of my application and cancellation of subsequent application in the Association.

Subscriber's signature:	Date (dd mm yy):
--------------------------------	-------------------------

Please complete and return the application form together with a cross cheque payable to "Hong Kong Association of Family Medicine and Primary Health Care Nurses Limited" to HKAFMPCN, c/o Ms Pauline TANG, Princess Margaret Hospital Nurses Quarters, LG1, 232 Lai King Hill Road, Kowloon. Enquiry: Ms Pauline TANG at 9730 2231

***Mandatory item need to be entered**