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**.*

***Name in English (BLOCK LETTERS)** Surname: Other names:	**Identification Documents** * First 4 digits of HKID / passport no.:
***Name in Chinese:**	***Gender:** ❑ Female ❑Male **Title**: ❑ Ms. ❑ Mrs. ❑ Mr. ❑ Dr ❑ Prof
***Correspondence Address:**	
Telephone No. Office: Home:	***Mobile:** / ***E-mail:**
Occupation /Job Title:	**Place of work:**

Education	Professional Qualification: (e.g. EN, RN, NS)
	Other Academic Qualification: (e.g. BSc, MBA, PhD)
Membership Type	❑ 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 ❑ Associated members: Any registered nurse/ enrolled nurse who is interested in Primary Health Care Nursing ❑ Affiliated members: Any personnel who is interested in primary health care practice ❑ Renewal of membership Membership No: _____

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

❑ Public Affair & membership ❑ Education committee ❑ Programme committee
❑ Executive/secretariat ❑ Conference activities
❑ 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.

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 Central Nursing Division, 1/F, OPD Block, Our Lady of Maryknoll Hospital. 118 Shatin Pass Road, Wong Tai Sin, Kowloon. Enquiry: Ms Pauline Tang at 96702250

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

***Mandatory item need to be entered**