



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.org/>

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: <input type="checkbox"/> Female <input type="checkbox"/> Male	
		Title: <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr <input type="checkbox"/> 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	<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 drive <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):			
<p>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.</p> <p>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.</p> <p>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 <u>Central Nursing Division, 1/F, OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon</u>. Enquiry: Ms Lancy Au Yeung at 2354 0558</p>			
Subscriber's signature:		Date (dd mm yy):	

*Mandatory item need to be entered