

香港西醫工會
HONG KONG DOCTORS UNION

Room 803-4, Hang Shing Bldg., 363-373, Nathan Road, Kowloon
E-mail: hkdu@mail@gmail.com Home Page: <http://hkdu.org> Tel. no.: 2388 2728 Fax no.: 2385 5275

Date _____

Dear Dr.

Thank you for your enquiry about the application for membership of this Union.

An Application Form is enclosed. Please complete and return it to the HKDU Secretariat together with a copy of practicing certificate and a cheque of applicable prescribed fee payable to "Hong Kong Doctors Union". The subscription of each year is from 1st July to 30th June.

- (i) Ordinary Member
 - (a) Entrance fee \$600 (waived during 15/4/2021 – 30/4/2022)
 - (b) Annual Subscription \$500

- (ii) Life, Honorary, Associate or Junior Associate Member
 - (a) **Entrance fee is waived**
 - (b) Life Member \$2,500 (15/4/2021 – 30/4/2022)
 - (c) Annual Subscription for Honorary Member \$250
 - (d) Annual Subscription for Associate Member \$240
 - (e) Annual Subscription for Junior Associate \$120

Such application will be referred to the next Council Meeting for approval. If approved, your name will be entered in the Register. Circulars of HKDU will be sent to you regularly.

If you are in private practice and want to receive information about our consumer activities, you may apply in writing for inclusion into the Consumer Mailing List by the enclosed Reply Slip.

Should you have any query, please contact HKDU Secretariat at tel. no. 2388 2728.

Yours sincerely,

Dr. Wu Chee Wo
Hon. Secretary
Hong Kong Doctors Union

Encl.

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APPLICATION FORM FOR MEMBERSHIP

To: Hong Kong Doctors Union

Date: _____

I wish to become a member of the Hong Kong Doctors Union and I hereby agree, if accepted to be a member of the said Union, to be bound by the Constitution and Rules of the Union and the By-Laws created therefrom.

Life Member Ordinary Member Associate Member Junior Associate

(Particulars to be stated fully and correctly by the Applicant.)

Name _____
(In English) (In Chinese)

Date of Birth _____ Sex _____

HKID Card No. _____ Medical Council Reg. No. _____

Year of Registration with the Medical Council of Hong Kong (MCHK) _____

*** (Photocopy of Annual Practising Certificate of the Applicant should be enclosed with this application form)**

Qualification(s) in the Register _____ Year _____
of MCHK _____ Year _____
_____ Year _____

Are you in the Specialist Register of MCHK? (Please tick) Yes No

If yes, which specialty? _____ Year _____

Address of Applicant:

Address A (Business/or name of Hospital): _____
_____ Tel: _____ Fax: _____

Address B (Business/or name of Hospital): _____
_____ Tel: _____ Fax: _____

Address C (Home): _____
_____ Tel: _____ Fax: _____

Please use the following Address for correspondence address: (Please tick)

Address A Address B Address C

E-mail address (if any): _____ Fax No. _____ Mobile Phone No. _____

Please add my E-mail address, fax number and mobile phone number for rapid communication among members and CME information. (Please tick)

(Signature of Applicant)

*If more forms are required, please photocopy this form for use. **Only the original copy of those duly completed and signed Application Form would be accepted.***