



# 香港微創外科學會

## HONG KONG SOCIETY OF MINIMAL ACCESS SURGERY

c/o The Federation of Medical Societies of Hong Kong, Duke of Windsor Building., 4/F, 15 Hennessy Road., Hong Kong  
Tel: (852) 2527 8898 Fax: (852) 2865 0345 Internet: <http://www.hksmas.org>

### MEMBERSHIP APPLICATION / RENEWAL FORM 2009-10

New Applicant  Renewal Membership

#### A. Membership Type: (Please tick as appropriate)

I would like to apply for **Life Membership**  Ordinary Member\* **Annual Membership**  Ordinary Member\*  
 Associate Member  Associate Member

\* Ordinary membership is limited to qualified Hong Kong medical practitioners practicing minimal access therapy.

#### B. Personal Particulars:

Title \_\_\_\_\_ Name in full (Surname first) \_\_\_\_\_ Sex  M  F  
Dr/Prof/Mr/Ms

Job Title \_\_\_\_\_ Specialty \_\_\_\_\_

Hospital / Institution \_\_\_\_\_ Department \_\_\_\_\_ Hospital \_\_\_\_\_

Correspondence Address \_\_\_\_\_

Tel No. \_\_\_\_\_ Fax No. \_\_\_\_\_ Email\* \_\_\_\_\_  
\* mandatory

#### C. Qualifications:

Academic Qualifications \_\_\_\_\_ Year Obtained \_\_\_\_\_

Professional Qualifications \_\_\_\_\_ Year Obtained \_\_\_\_\_

\_\_\_\_\_ Year Obtained \_\_\_\_\_

\_\_\_\_\_ Year Obtained \_\_\_\_\_

#### D. Experience in Laparoscopic Surgery:

Type of Operations Surgeons / Assistant No. of Cases

\_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposer# \_\_\_\_\_ Name in Block Letters \_\_\_\_\_

Signature of Seconder# \_\_\_\_\_ Name in Block Letters \_\_\_\_\_

# Both Proposer and Seconder must be ordinary members of Hong Kong Society of Minimal Access Surgery

#### Registration Fee

Admission Fee (New member) Ordinary Member HK\$250  Associate Member HK\$50

\* Admission Fee will be collected from new applicants

Life Subscription Ordinary Member HK\$1500  Associate Member HK\$300

Annual Subscription Ordinary Member HK\$250  Associate Member HK\$50

#### Payment

■ A cheque for HK\$ \_\_\_\_\_ made payable to "Hong Kong Society of Minimal Access Surgery Limited" is enclosed, with recipient address as Secretariat, Hong Kong Society of Minimal Access Surgery Limited, c/o Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Chaiwan, Hong Kong.

■ Please debit my credit card: Type:  Visa /  Master

Name: \_\_\_\_\_ Card No: \_\_\_\_\_ Expiry date: \_\_\_\_\_

Amount: HKD/USD \_\_\_\_\_ Signature: \_\_\_\_\_

\*\* For enquiry please contact Ms Jelly Cheng (Tel: 25956417, Fax: 25153195).