Appendix A

APPLICATION FORM

Application by Health Care Provider for Enrolment in the Health Care Voucher Scheme, Vaccination Subsidy Scheme, Residential Care Home Vaccination Programme and Primary Care Directory ("Scheme/Programme")

Application for enrolment by a health care provider to the Scheme/Programme is subject to consideration by the Government of the Hong Kong Special Administrative Region ("Government"), of all the circumstances and factors as the Government thinks fit which include but are not limited to the conduct, integrity, reputation, management and past and recent performance of the health care provider. In any event, acceptance of enrolment of a health care provider in the Scheme/Programme is at the absolute discretion of the Government.

Please complete with a black or blue pen in BLOCK LETTERS, and put a "✓" in ☐ or * delete as appropriate.

Enrolment Reference No.: _____ (Official Use Only)

To: The Government

Part I – Scheme(s)/Programme to which this application relates and Interpretation

I, the person whose particulars appear in Section (A) of Part II below ("Applicant"), hereby apply to the Government to enrol in the following scheme(s)/programme –

☐ Health Care Voucher Scheme ("HCVS")

☐ Vaccination Subsidy Scheme ("VSS")#

☐ Residential Care Home Vaccination Programme ("RVP")

☐ Primary Care Directory ("PCD")#

[The PCD is overseen by the Primary Healthcare Office under the Food and Health Bureau of the Government. Applications for enrolment in the PCD only should be submitted directly to the PCD at https://apps.pcdirectory.gov.hk/SP/Main/Main.aspx]

For a Registered Medical Practitioner to apply for enrolment in VSS and/or RVP, he/she has tobe enrolled in the PCD. If the applicant has not enrolled in the PCD, he/she is required to enrol in the PCD together with VSS and/or RVP in this enrolment application.

I, the Applicant, hereby declare that :-

☐ I have already enrolled in the PCD.

☐ I have not yet enrolled in the PCD and hereby apply to enrol in the PCD.

[Unless the context otherwise requires, capitalized terms used in this Application Form shall have the same meanings ascribed to them in Appendices C, F, J and K with respect to the relevant scheme(s)/programme.]

Part II – Application and Particulars of the Applicant and Medical Organization

I, the Applicant, provide the following information in support of this application –

(A) Personal particulars

Name (as shown on Hong Kong Identity Card)

(in English): _____

(in Chinese): _____

Hong Kong Identity Card no.: _____

Daytime contact telephone no.: _____

Contact e-mail address: _____ *(please provide one e-mail address)*

Fax no.: _____

Correspondence address: _____

_____

Please provide documentary proof of correspondence address such as public utility bill or bank statement.

(B) Particulars of profession

I am practising *in my own name / under the name of or for the Medical Organization set out in Section (C) as:

Please tick one box ONLY and provide a copy of the relevant valid practising certificate (except in the case of a registration under section 85 of the Chinese Medicine Ordinance (Cap. 549) ("CMO")). For the Professional Registration Number, it refers to the number assigned by relevant professional body or council to the Applicant upon registration with that body or council.

For application for enrolment in HCVS, VSS, RVP and PCD –

☐ a registered medical practitioner (within the meaning of the Medical Registration Ordinance (Cap. 161)) ("MRO") who holds a valid practising certificate issued under the MRO (Professional Registration Number: _____)

For application for enrolment in HCVS or PCD –

☐ a registered dentist (within the meaning of the Dentists Registration Ordinance (Cap. 156) ("DRO")) who holds a valid practising certificate issued under the DRO (Professional Registration Number:_____)

☐ a registered Chinese medicine practitioner (within the meaning of the CMO) who either:

(i) holds a valid practising certificate issued under the CMO (Professional Registration Number:_____) ; or

(ii) is registered under section 85 of the CMO (Professional Registration Number: _____).

For application for enrolment in HCVS only –

☐ a registered chiropractor (within the meaning of the Chiropractors Registration Ordinance (Cap. 428) ("CRO")) who holds a valid practising certificate issued under the CRO (Professional Registration Number:_____)

☐ a registered nurse (within the meaning of the Nurses Registration Ordinance (Cap. 164) ("NRO")) who holds a valid practising certificate issued under the NRO (Professional Registration Number:_____)

☐ an enrolled nurse (within the meaning of the NRO) who holds a valid practising certificate issued under the NRO (Professional Registration Number:_____ _____)

☐ a medical laboratory technologist registered under the Supplementary Medical Professions Ordinance (Cap. 359) ("SMPO") who holds a valid practising certificate issued under the SMPO (Professional Registration Number:_____)

☐ an occupational therapist registered under the SMPO who holds a valid practising certificate issued under the SMPO (Professional Registration Number:_____)

☐ a physiotherapist registered under the SMPO who holds a valid practising certificate issued under the SMPO (Professional Registration Number:_____)

☐ a radiographer registered under the SMPO who holds a valid practising certificate issued under the SMPO (Professional Registration Number:_____)

☐ an optometrist registered under the SMPO (in Part I of the register) who holds a valid practising certificate issued under the SMPO (Professional Registration Number: _____)

(C) The Medical Organization

The meaning of "Medical Organization" can be found in the Definitions at Appendices C, J and K with respect to the relevant scheme(s)/programme as specified by the Applicant in Part I above.

Name of Medical Organization:

(in English):_____

(in Chinese):_____

Business Registration Number: _____
Daytime contact telephone no.: _____
Contact e-mail address: _____
Fax no.: _____
Correspondence address: _____

_____

Please provide a copy of the Business Registration Certificate and/or documentary proof of correspondence address such as public utility bill or bank statement.

(D) Relationship between parties (Please select one of the following items)

The relationship between me, the Applicant, and the Medical Organization is:

☐ sole proprietor of the Medical Organization

☐ partner of the Medical Organization

☐ shareholder of the Medical Organization

☐ director of the Medical Organization

☐ employee of the Medical Organization

☐ others (please specify:_____)

(E) Place of practice and service fee

If you plan to provide outreaching vaccination services at non-clinic settings, please complete Practice No. 5 on Page 9.

The scheme(s)/programme to be enrolled under the profession under Section (B), practice name, address, telephone number and service fees (if applicable) are:

Practice No. (1):
Please provide a copy of the documentary proof for address of the practice, such as public utility bill or bank statement.

Name (in English):_____

(in Chinese):_____

Address (in English):_____

(in Chinese):_____

Telephone no.:_____

Scheme(s)/Programme to which this Application relates:

☐ HCVS ☐ VSS ☐ RVP ☐ PCD

For application for enrolment in PCD:

Type of practice (choose one):

☐ Non-governmental Organization ☐ Private ☐ University

For application for enrolment in VSS:

Service fee charged per vaccination at the above practice (**inclusive of all fees** related to the vaccination) **AFTER deducting Government subsidy**:

Eligible Groups / Vaccine Type^	**Pregnant Women**	**Children aged 6 months to less than 12**	**Persons aged 50 to 64**	**Elderly aged 65 or above**	**Persons with Intellectual Disability**	**Recipients of Disability Allowance / standard rate of "100% disabled" or "requiring constant attendance" under CSSA**
Seasonal Influenza Vaccine						
QIV (IIV) @						
QIV (LAIV) @	N/A		N/A			
QIV (RIV) @		N/A				
Pneumococcal Vaccine						
23vPPV	N/A				N/A	
PCV13	N/A				N/A	

Practice No. (2):

Please provide a copy of the documentary proof for address of the practice, such as public utility bill or bank statement.

Name (in English):_____

(in Chinese):_____

Address (in English):_____

(in Chinese):_____

Telephone no.:_____

Scheme(s)/Programme to which this Application relates:

☐ HCVS ☐ VSS ☐ RVP ☐ PCD

For application for enrolment in PCD:

Type of practice (choose one):

☐ Non-governmental Organization ☐ Private ☐ University

For application for enrolment in VSS:

Service fee charged per vaccination at the above practice (**inclusive of all fees** related to the vaccination) **AFTER deducting Government subsidy**:

Eligible Groups / Vaccine Type^	**Pregnant Women**	**Children aged 6 months to less than 12**	**Persons aged 50 to 64**	**Elderly aged 65 or above**	**Persons with Intellectual Disability**	**Recipients of Disability Allowance / standard rate of "100% disabled" or "requiring constant attendance" under CSSA**
Seasonal Influenza Vaccine						
QIV (IIV) @						
QIV (LAIV) @	N/A		N/A			
QIV (RIV) @		N/A				
Pneumococcal Vaccine						
23vPPV	N/A				N/A	
PCV13	N/A				N/A	

Practice No. (3):

Please provide a copy of the documentary proof for address of the practice, such as public utility bill or bank statement.

Name (in English):_____

(in Chinese):_____

Address (in English):_____

(in Chinese):_____

Telephone no.:_____

Scheme(s)/Programme to which this Application relates:

☐ HCVS ☐ VSS ☐ RVP ☐ PCD

For application for enrolment in PCD:

Type of practice (choose one):

☐ Non-governmental Organization ☐ Private ☐ University

For application for enrolment in VSS:

Service fee charged per vaccination at the above practice (**inclusive of all fees** related to the vaccination) **AFTER deducting Government subsidy**:

Eligible Groups / Vaccine Type^	**Pregnant Women**	**Children aged 6 months to less than 12**	**Persons aged 50 to 64**	**Elderly aged 65 or above**	**Persons with Intellectual Disability**	**Recipients of Disability Allowance / standard rate of "100% disabled" or "requiring constant attendance" under CSSA**
Seasonal Influenza Vaccine						
QIV (IIV) @						
QIV (LAIV) @	N/A		N/A			
QIV (RIV) @		N/A				
Pneumococcal Vaccine						
23vPPV	N/A				N/A	
PCV13	N/A				N/A	

Practice No. (4):

Please provide a copy of the documentary proof for address of the practice, such as public utility bill or bank statement.

Name (in English):_____

(in Chinese):_____

Address (in English):_____

(in Chinese):_____

Telephone no.:_____

Scheme(s)/Programme to which this Application relates:

☐ HCVS ☐ VSS ☐ RVP ☐ PCD

For application for enrolment in PCD:

Type of practice (choose one):

☐ Non-governmental Organization ☐ Private ☐ University

For application for enrolment in VSS:

Service fee charged per vaccination at the above practice (**inclusive of all fees** related to the vaccination) **AFTER deducting Government subsidy**:

Eligible Groups / Vaccine Type^	**Pregnant Women**	**Children aged 6 months to less than 12**	**Persons aged 50 to 64**	**Elderly aged 65 or above**	**Persons with Intellectual Disability**	**Recipients of Disability Allowance / standard rate of "100% disabled" or "requiring constant attendance" under CSSA**
Seasonal Influenza Vaccine						
QIV (IIV) @						
QIV (LAIV) @	N/A		N/A			
QIV (RIV) @		N/A				
Pneumococcal Vaccine						
23vPPV	N/A				N/A	
PCV13	N/A				N/A	

Practice No. (5): (Only applicable to VSS outreaching vaccination at non-clinic settings)

Name (in English):_____

(in Chinese):_____

Address (in English):_____

(in Chinese):_____

Telephone no.:_____

Service fee charged per vaccination at non-clinic settings (**inclusive of all fees** related to the vaccination) **AFTER deducting Government subsidy**:

Eligible Groups / Vaccine Type^	**Pregnant Women**	**Children aged 6 months to less than 12**	**Persons aged 50 to 64**	**Elderly aged 65 or above**	**Persons with Intellectual Disability**	**Recipients of Disability Allowance / standard rate of "100% disabled" or "requiring constant attendance" under CSSA**
Seasonal Influenza Vaccine						
QIV (IIV) @						
QIV (LAIV) @	N/A		N/A			
QIV (RIV) @		N/A				
Pneumococcal Vaccine						
23vPPV	N/A				N/A	
PCV13	N/A				N/A	

^ QIV (IIV): Quadrivalent inactivated influenza vaccine (injectable)
QIV (LAIV): Quadrivalent live attenuated influenza vaccine (nasal spray)
QIV (RIV): Quadrivalent recombinant influenza vaccine (injectable)
23vPPV: 23-valent pneumococcal polysaccharide vaccine
PCV13: 13-valent pneumococcal conjugate vaccine

^ VSS enrolled doctors should note the contraindications and the age range recommended for use of the vaccine when considering the provision of vaccination services to any eligible group.

@ Only the service fee of QIV (IIV) will be displayed at the Online Service Directory of the Department of Health.

With respect to the relevant scheme(s)/programme the enrolment in which is being applied for, the name of applicant, practice's name(s), address(es), telephone number(s), and service fee (if applicable) provided above will be published in the directories of the HCVS, VSS, RVP and PCD and/or other Government programmes to promote primary care, as appropriate on the internet or in hardcopies for reference by the public. For enrolment in the PCD, your Professional Registration Number and type(s) of practice, as well as other practice information provided will also be displayed in the PCD.

Part III - Undertaking and Declaration

HCVS, VSS and RVP

In consideration of the Government, as represented by the Director of Health, considering and/or approving this application for enrolment in the relevant scheme(s)/programme as specified by the Applicant in Part I of this Application Form, the Applicant and the Medical Organization hereby jointly and severally acknowledge, confirm, undertake, warrant, declare and agree with continuing effect as follows:

(a) we have carefully read and fully understood the Application Form and all other relevant Transaction Documents with respect to the relevant scheme(s)/programme as specified by the Applicant in Part I of this Application Form;

(b) the Applicant is eligible to apply for enrolment in the scheme(s)/programme as specified by the Applicant in Part I of this Application Form according to the Covering Notes for Application by Health Care Provider for Enrolment in the Health Care Voucher Scheme, Vaccination Subsidy Scheme, Residential Care Home Vaccination Programme and Primary Care Directory ("Covering Notes");

(c) all information and documents provided to the Government in or with this Application Form and from time to time in relation to the scheme(s)/programme as specified by the Applicant in Part I of this form (whether in any of our own hands or not) are up-to-date, true, accurate and complete in all respects;

(d) none of us has withheld, and none of us is aware of, any material facts or circumstances that have not been disclosed to the Government which may influence the assessment of this application or the decision of the Government in considering whether or not to approve this application;

(e) this application may not be processed by the Government if any of us fails to provide all information and documents required by the Government;

(f) each of us shall submit to the Government such other information and documents as the Government may require from time to time in relation to this application;

(g) each of us shall inform in writing the Programme Management and Vaccination Division , Department of Health of the Government (i) 2 working days before raising the service fee as specified in Part II, Section (E) of the Application Form and (ii) immediately of any change in any information submitted in relation to this application or if any such information is no longer applicable, true, accurate or complete and of any material change in circumstances affecting the Applicant's eligibility for enrolment in the scheme(s)/programme as specified by the Applicant in Part I of this Application Form or otherwise this application including any incidents of professional misconduct or negligence (whether substantiated or alleged);

(h) the Medical Organization set out in Section (C) of Part II of this Application Form is a private sector organization or a non-governmental organisation;

(i) the Applicant is not suspended or prohibited from practising in the profession indicated by the Applicant in Section (B) of Part II of this Application Form;

(j) until this application is rejected by the Government or, if this application is successful, until the Applicant ceases to be an Enrolled Health Care Provider, each of us shall comply at all times with all the terms and conditions of this Application Form and the other relevant Transaction Documents with respect to the relevant scheme(s) as specified by the Applicant in Part I of this Application Form;

(k) the Government, any of its agents or officers (including the Director of Health) and any other persons authorized by the Government shall have full access to and may transfer and use the Applicant's personal data provided in relation to the scheme(s) for the purposes set out in the Statement of Purpose with respect to the relevant scheme(s)/programme as specified by the Applicant in Part I of this form, and the word "use" shall have the meaning given to it under the Personal Data (Privacy) Ordinance (Cap. 486);

(l) the Applicant hereby gives consent for each of the following professional regulatory board and council to release at any time the Applicant's personal data held by any of them to the Director of Health, the Government, any agents or officers of the Government and any other person authorized by the Government for the purpose of processing this application and, where necessary, for a verification procedure by electronic means to be carried out for that purpose:

(i) Medical Council of Hong Kong;
(ii) Dental Council of Hong Kong;
(iii) Chinese Medicine Council of Hong Kong;
(iv) Chiropractors Council of Hong Kong;
(v) Nursing Council of Hong Kong;
(vi) Physiotherapists Board of Hong Kong;
(vii) Occupational Therapists Board of Hong Kong;
(viii) Medical Laboratory Technologists Board of Hong Kong;
(ix) Radiographers Board of Hong Kong; and
(x) Optometrists Board of Hong Kong.

(m) each of us fully understands that non-disclosure or misrepresentation of any information required or provided in connection with this application shall entitle the Government to reject this application;

(n) if any information, undertaking, warranty or declaration given by any of us in this Application Form is not up-to-date, true, accurate or complete or if any of us fails to comply with any provision of this Undertaking and Declaration, without

prejudice to any powers, rights, remedies and claims that the Government may have under this Undertaking and Declaration or in law, this application shall be rejected immediately and if this application has already been approved, the approval for the Applicant's enrolment in the relevant scheme(s)/programme as specified by the Applicant in Part I of this Application Form shall be revoked immediately;

(o) the Authorized Signatory(ies) stated in Section (B) of Part V is duly authorized by the Medical Organization to execute this Application Form for and on behalf of the Medical Organization and to bind it by his/their signatures(s) to the terms and conditions of this Application Form and all other relevant Transaction Documents with respect to the relevant scheme(s)/programme as specified by the Applicant in Part I of this Application Form; and

(p) this Undertaking and Declaration shall be governed by and construed in accordance with the laws of the Hong Kong Special Administrative Region of the People's Republic of China ("Hong Kong") and each of us shall irrevocably submit to the exclusive jurisdiction of the Courts of Hong Kong.

PCD

The Applicant has carefully read and fully understood the Terms and Conditions and all other relevant documents with respect to the PCD including the Notes on Use of Personal Data as set out in Appendix F and updated at https://apps.pcdirectory.gov.hk/SP/Main/Main.aspx from time to time.

Part IV – Government Disclaimers

1. Whilst the information provided by the Government in this Application Form and the Covering Notes have been prepared in good faith, they are provided to the Applicant and the Medical Organization (if applicable) on an "as is" basis without warranty of any kind. Neither the Government, nor any of its officers, agents or advisors, accepts any liability or responsibility as to, or in relation to, the sufficiency, accuracy, completeness, suitability or timeliness of the information contained in this Application Form, the Covering Notes or any other written or oral information which is, has been or will be provided or made available to any Applicant or Medical Organization (if applicable); nor do they make any representation, statement, undertaking or warranty, express or implied, with respect to such information or to the information on which the Application Form or the Covering Notes are based. Any liability in respect of any such information or any inaccuracy in or omission from the Application Form or the Covering Notes is expressly disclaimed. Nothing in the Application Form, the Covering Notes nor in any other written or oral information which is, has been or will be provided or made available to any Applicant should be relied on as a representation, statement or warranty as to the intentions, policy or action in future of the Government, its officers or agents.

2. Neither the Covering Notes nor any invitation for submission of applications under the scheme(s)/programme as specified in Part I of this form shall constitute an offer.

3. The submission of an application for enrolment by an Applicant shall be taken to be an acceptance of the terms of this disclaimer by the Applicant and the Medical Organization (if applicable).

Part V – Execution

(A) The Applicant

Applicant's signature: _____

Name of Applicant as shown on Hong Kong Identity Card: (in English): _____

(in Chinese): _____

Date: _____

(B) The Medical Organization (should be completed for enrolment in HCVS, RVP and/or VSS)

Official Stamp and authorized signature for and on behalf of the company/ organization

Name in block letters (Authorized Signatory): _____

Position: _____

Name of company/ organization: _____

Date: _____

I/We, the above Applicant/ the above Applicant and Medical Organization, have read and agree to the contents in Parts I to IV of this Application Form and solemnly repeat each and every statement set out in the Undertaking and Declaration as set out in Part III of this Application Form. I/We also declare that the information given by me/us in this Application Form is up-to-date, true, accurate and complete in all respects.

I/We also agree that by signing this Application Form, a binding agreement on the terms and conditions set out in Appendices C, F, J and K with respect to the scheme(s)/programme the enrolment in which is being applied for as indicated in Part I hereof shall be constituted between the Government and me/us on the date on which the Government notifies the Applicant in writing the approval of this application.

Statement of Purpose

Purposes of Collection

1. The personal data provided will be used by the Department of Health (for enrolment in the HCVS, VSS and/or RVP) and/or the Food and Health Bureau (for enrolment in the PCD) for one or more of the following purposes:

   (a) processing the application for enrolment in the scheme(s)/programme as specified in Part I of this form, payment by the Government, and the administration and monitoring of the scheme(s)/programme as specified in Part I of this form;
   (b) Government programmes to promote primary care;
   (c) for statistical and research purposes; and
   (d) any other legitimate purposes as may be required, authorized or permitted by law.

2. The provision of personal data in the application form is voluntary. If you do not provide sufficient information, we may not be able to process your application.

Classes of Transferees

3. The personal data you provide are mainly for use within the Department of Health (for enrolment in the HCVS, VSS and/or RVP) and/or the Food and Health Bureau (for enrolment in the PCD) but they may also be disclosed to other Government bureaux and departments, respective professional regulatory boards and councils and other organizations for the purpose stated in paragraph 1 above, if required.

Access to Personal Data

4. You have a right to request access to and to request the correction of your personal data under sections 18 and 22 and Data Protection Principle 6, Schedule 1 of the Personal Data (Privacy) Ordinance (Cap. 486). A fee may be imposed for complying with a data access request.

Enquiries

5. Enquiries concerning the personal data provided, including the making of access and correction, should be addressed to the respective officer:

HCVS, VSS and RVP

For medical practitioners

Executive Officer (Vaccination Subsidy Scheme)
Programme Management and Vaccination Division
Department of Health
3/F, Two Harbourfront,
18 – 22 Tak Fung Street,
Hung Hom, Kowloon
Telephone No.: 2125 2125

For healthcare service providers in other professions

Executive Officer (Health Care Voucher),
Health Care Voucher Division
Department of Health
Suites 901-4, 9/F, AXA Tower, Landmark East
100 How Ming Street, Kwun Tong, Kowloon
Telephone No.: 3582 4102

PCD

Executive Officer (District Health Centre Team)A
Primary Healthcare Office
Food and Health Bureau
The Government of the Hong Kong Special Administrative Region
11/F, The HUB, 23 Yip Kan Street
Wong Chuk Hang
Hong Kong
Telephone: 2205 2491
Fax number: 2556 2638
Email Address: pho@fhb.gov.hk