



地區康健中心
District Health Centre

District Health Centre (DHC)
Network Service Provider Enrolment Form
(For Allied Health Professionals)

Part 1 – Enrolling District (Please select one district from the below drop-down list)	
-- Select District --	▼

Part 2 – Personal Particulars			
Full Name (as on Hong Kong Identity Card)	(English)	Surname:	Given Name:
	(Chinese)		
*HKID Card No.		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
*Daytime Telephone No.			
*^Email Address <i>(for future correspondence use)</i>			

* will not be disclosed to the public.

^ For update of email address, the system will automatically email a link for your confirmation to complete the update procedure.

Part 3 – Professional Qualification(s)		
Type of Profession	<input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physiotherapist	
	Registration No.:	
	Name of Issuing Authority in Hong Kong:	
	Practising Certificate No.:	
	Validity until (DD/MM/YYYY):	
	<input type="checkbox"/> Dietitian <input type="checkbox"/> Podiatrist <input type="checkbox"/> Speech Therapist	
Professional Qualification (in English)	Professional Qualification (in Chinese)	Year Obtained

Part 4 – Practice Information			
Practice Name	(English)		
	(Chinese)		
Relationship with the Practice <i>(If the Name of Practice is an organization, instead of the medical and healthcare practitioner himself/herself, please indicate the relationship between the organization and the medical and healthcare practitioner)</i>			
Practice Address (in English)	Room/Floor		
	Building		
	Street		
	District		
Practice Address (in Chinese)	地區		
	街道		
	大廈		
	室/樓層		
Practice Telephone No.		Practice Fax No.	
Opening Hours <i>(must fill in exact time)</i>			
Day	Time (From)		Time (To)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Public Holidays			
By Appointment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Service Fee <i>(exact amount and not a range)</i>			HK\$ _____

Part 5 – Other Information	
Agreed to use DHC IT module and Electronic Health Record Sharing System (eHRSS)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enrolled in Elderly Health Care Voucher Scheme	<input type="checkbox"/> Yes <input type="checkbox"/> No
eHRSS	User ID
	Healthcare Provider ID
	Healthcare Institution ID, if applicable

Part 6 – Declaration	
<p>For application of the Network Service Provider of DHC, I, _____ (full name) the undersigned, hereby confirm that the above given information is correct.</p>	
Signature	Date of Submission

Checklist for Submission of Application

- For all applications, attach a scanned copy of the following with the Enrolment Form:
 - Proof of Professional Qualification(s)

- For Occupational Therapist, Optometrist and Physiotherapist related applications, attach a scanned copy of the following with the Enrolment Form:
 - Valid Certificate of Registration in the respective statutory board in Hong Kong; AND
 - Valid Practising Certificate

- Submit this Network Service Provider Enrolment Form together with above scanned copy or copies to:

Option 1: DHC Operator(s)

(HCPs practising in the corresponding and adjacent districts of the DHC can join the DHC network)

Contact information of individual DHC Operators can be found at:

<https://www.dhc.gov.hk/en/dhc.html>

Option 2: Primary Healthcare Office

Contact information of the Primary Healthcare Office can be found at:

https://www.fhb.gov.hk/pho/main/contact_us.html?lang=2

Note:

1. Additional information may be required by individual DHC Operators.
2. All NSPs on this list must fulfil the respective applicable NSP requirements with valid documentary proof (if required). For any non-conforming cases, please write to PHO separately with justifications for due consideration.