地區康健中心
District Health Centre

District Health Centre (DHC)

Healthcare Professionals engaged by the Operator

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	☐ Male ☐ Female
*Daytime Telephone No.				
*^Email Address *(for future correspondence use)*				

** 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	☐ Occupational Therapist ☐ Optometrist ☐ Physiotherapist		
	Registration No.:		
	Name of Issuing Authority in Hong Kong:		
	Practising Certificate No.:		
	Validity until (DD/MM/YYYY):		
	☐ Dietitian ☐ Podiatrist ☐ Speech Therapist		
Professional Qualification (in English)		Professional Qualification (in Chinese)	Year Obtained

Part 4 – Practice Information				
Practice Name	(English)			
	(Chinese)			
Relationship with the Practice *(If the Name of Practice is an organisation, instead of the medical and healthcare practitioner himself/herself, please indicate the relationship between the organisation and the medical and healthcare practitioner)*				
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 *(must fill in exact time)*				
Day	Time (From)		Time (To)	
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				
Public Holidays				
By Appointment	☐ Yes ☐ No			
Service Fee *(exact amount and not a range)*			HK$_____	

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

Part 6 – Declaration	
For application of the Healthcare Professionals engaged by the Operator of DHC, **I,_____(full name) the undersigned, hereby confirm that the above given information is correct.**	
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 Healthcare Professionals engaged by the Operator 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 Commission

Contact information of the Primary Healthcare Commission can be found at: https://www.healthbureau.gov.hk/phcc/main/contact_us.html?lang=2

Note:

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