Hospital Authority Volunteer Registration Form

Welcome and thank you for volunteering your services to the Hospital Authority. As the major provider of medical services in Hong Kong, the primary responsibility of the Hospital Authority is to ensure that the health and safety of patients, visitors, medical staff and volunteers are protected, while volunteers provide services at the hospitals. If under certain conditions, an applicant may endanger the safety of staff, patients, visitors or volunteers, the Hospital Authority may not be able to permit this applicant to become or continue to be a volunteer of this Authority.

Therefore, the Hospital Authority stipulates that

- All volunteers must register with the Hospital Authority or its subsidiary public hospital before taking part in volunteer activities. The Hospital Authority and its subsidiary public hospitals and institutions will process all data registered in accordance with the “Personal Data (Privacy) Ordinance”.
- All registered volunteers must follow the guidelines for volunteer services, issued by the Hospital Authority.

All applicants must read this notice before disclosing any personal data to the Hospital Authority.

The Hospital Authority is a statutory body, responsible for managing public hospitals and institutions under its sole ownership or control (including subsidiary companies or subsidiary institutions of the Hospital Authority). Our staff may request you to provide your personal data (including your health condition), or collect your personal data from the subsidiary institutions of the Hospital Authority or any relevant third party. The data collected will be utilized to process your application / registration as a volunteer of the Hospital Authority.

Any personal data you provide must be correct and complete. Any incorrect or incomplete information will affect our consideration of your application / registration.

Please note that any personal data collected under the above-mentioned conditions may be provided to：

- Relevant parties of the Hospital Authority or the subsidiary institutions of the Hospital Authority.
- Doctors, health care staff or other relevant parties beyond the Hospital Authority or the subsidiary institutions of the Hospital Authority
- Relevant government departments or management institutions under conditions permitted by law. The data may also be disclosed for the need of public benefit.

Apart from the above-mentioned conditions, we will only utilize, disclose or transfer the personal data you provide to the Hospital Authority, under the following conditions：

- For use in your application or registration as a volunteer of the Hospital Authority, or other directly related purposes, OR
- Under circumstances permitted by law.

We will seek your consent before utilizing your personal data for other purposes.

If you wish to review / amend your personal data possessed by the Hospital Authority or the subsidiary institutions of the Hospital Authority, in accordance with the “Personal Data (Privacy) Ordinance”, please contact the relevant data controller during office hours.

Address：____

Hospital Authority Volunteer Registration Form
(Hospital)

Section A

Name in Chinese：	Name in English：	
Date of Birth： Year Month Day	Gender： Male Female	
Type of identification document and number：		
Occupation：	Religion	Affiliated institution / group：
Education Level: ☐ Primary ☐ Secondary ☐ Post Secondary ☐University or above ☐ Others		
Correspondence address：		
Telephone (Home)：	Telephone (Office) ：	Mobile phone / Pager：
E-mail address：		
Contact person in case of emergency：		Relationship with volunteer：
Telephone (Home)：	Telephone (Office) ：	Mobile phone / Pager：

Section B

1. Immunization history

i) Measles, mumps, rubella 3-in-1 vaccine Yes No Previous Infection: Please specify ________
ii) Chicken pox Yes No Previous Infection: Please specify ________
iii) Hepatitis B Yes No Previous Infection: Please specify ________

2. Medical record：

- Cancer: Please specify ___________________
- Kidney disease
- Diabetes
- Lupus
- Others ___________________
- Liver disease
- Lung disease
- Heart disease
- Mental illness: Please specify ___________

3. (For Female Only)

Are you pregnant? Yes _________Week Pregnant No

Volunteer Registration Form (Cont’d)

Confidentiality and Participation Agreement

Upon signing this agreement, I agree

1. To respect the privacy of patients and staff. Apart from issues, which are appropriate for discussion during meetings with hospital staff, I will not mention any information, which I hear, see, or read in the hospital or obtain through other channels, in private gathering.
2. That the hospital is a place where patients receive treatment and recover. Providing volunteer services in such an environment bears the risk of being infected by disease. I also understand that I will attend an infection-control training program, from which I will acquire knowledge and skills of infection prevention. I will also follow all guidelines in respect to disease prevention measures provided by the medical staff, in order to protect my health and that of others.
3. To provide service to the institution without any guarantee of receiving compensation or employment in the future.
4. To report to the relevant party, any accidents or injuries which involve myself when providing volunteer service.
5. To dress properly and wear the volunteer identity card issued by the hospital, when providing volunteer service.
6. To stop participating in any on-going or up-coming volunteer activities if I do not feel well or have a fever.
7. That I must inform the designated person if I cannot show up on time, due to illness or fever, or any other reasons.
8. Be punctual at work and endeavor to provide service, or to provide prior notification if I cannot carry out my duty, so that other arrangements can be made.

I also agree that during the course of providing volunteer service, I will not be involved in any commercial activities.

I understand that before receiving any volunteer work, I will have to go through interview, training and orientation activities. I also understand that the Hospital Authority or the subsidiary institutions of the Hospital Authority reserve the right to terminate my registration as a volunteer, under the following circumstances: (a) I cannot abide by the policies, regulations or ordinances of the Hospital Authority, or (b) I fail to show up without prior notice, or (c) my working attitude and performance are unsatisfactory, or (d) under any conditions, the hospital considers that my volunteer work is not beneficial to the hospital.

I have read and agreed with all the Terms and Conditions above.

I hereby confirm that all the data provided above is correct.

Signature of applicant: _________________________ Date: ___________________

Participation Agreement for Applicants Under 18 Years Old

I agree to allow my son / daughter to participate in volunteer service at your hospital. I understand that the hospital is a place where patients receive treatment and recover. My son / daughter, by providing volunteer service in such an environment, bears the risk of being infected by disease. I also understand that my son / daughter will attend an infection control training program, from which he /she will acquire knowledge and skills of infection prevention. He / she will also follow all guidelines with respect to disease prevention measures provided by the medical staff, in order to lower the risk to himself / herself and others.

Signature of parents / guardian: ____________________ Date: ________________