# Kwai Chung Hospital 葵涌醫院
# Medical Certification Application Form 醫療證明書申請表

( ☐*Please ✓ where appropriate  請在適當空格上加上「✓」號*)

**1. Particulars of patient:**
**病人資料**

(a) Name (English)
姓名 (英文)  _____  (Chinese) (中文)  _____

(b) Sex  ☐ Male  ☐ Female  (c) Age  _____  (d) Date of birth (dd/mm/yyyy)
性別  男  女  年齡  出生日期 (日/月/年)  _____

(e) HKID card number
香港身份證號碼  _____  /  Passport number
護照號碼  _____

(f) Address
地址  _____

(g) Telephone number
聯絡電話號碼  _____  (g) Email address
電郵地址  _____

*If the HKID card number is provided, no copy or physical production of the HKID card is required in case the number provided is accurate and corresponds to the number recorded on HA's database. If not, a true copy of the HKID card will be required for verification. Alternatively, the HKID card may be physically produced for verification at our hospital.*
若提交香港身份證號碼，而提交的號碼正確及與醫管局資料庫所記錄的號碼相符，無須親身出示香港身份證正本或提交真確副本。否則，須提交香港身份證的真確副本，或親身向本院出示香港身份證正本，以供查核。

*If the passport number is provided, please produce in person the original or provide a true copy of the passport of the patient when submitting this medical certification application form to our hospital.*
若提交護照號碼，請在向本院提交本「醫療證明書申請表」時，親身出示病人的護照正本或提交真確副本。

**2. Request details:**
**申請詳情**

| (a) Specialty:<br>所屬病科 | ☐ Psychiatry<br>精神科 | ☐ Clinical psychology<br>臨床心理科 | ☐ Occupational therapy<br>職業治療部 |
| --- | --- | --- | --- |
| | ☐ Physiotherapy<br>物理治療部 | ☐ Dietetic<br>營養部 | ☐ Speech therapy<br>言語治療部 |
| | ☐ Other (please specify)<br>其他(請註明) | | |

| (b) Designated form(s) attached for completion:<br>附上需填寫的指定表格 | ☐ Parking Certificate for Drivers Who Carry People with Mobility Disabilities (Form: TD544)<br>司機接載行動不便的殘疾人士泊車證明書 (表格 TD544) |
| --- | --- |
| | ☐ Easy-Access Bus - Elderly Transport Service Membership Application Form<br>易達巴士 - 長者接載服務會員申請表 |
| | ☐ Free Delivery Service Provided by Supermarkets for Persons with Disabilities<br>超級市場為殘疾人士提供免費送貨服務 |
| | ☐ Mobility Impairment Certification (The Hong Kong Society for Rehabilitation)<br>行動不便證明書 (香港復康會復康巴士) |
| | ☐ Medical Assessment Form for The Electric Wheelchair Helping Self-improvement Fund Application<br>公益金電動輪椅助你自強基金醫療評估表格 |
| | ☐ Certificate for Picking Up or Setting Down of Disabled Passengers in Restricted Zones<br>殘疾乘客在限制區上落車證明書 (香港社會服務聯會) |
| | ☐ Certificate of Disability Type for Healthy Teeth Collaboration<br>護齒同行傷殘類別證明書 |
| | ☐ Certification of Disability - Recruitment of Assistant Clerical Officer and/or Clerical Assistant (CA)<br>殘疾證明書 - 助理文書主任 / 文書助理公開招聘 |
| | ☐ Medical Certification on Investigation / Purchase of drugs as recommended by the Doctor of HA (Vocational Training Council) |
| | ☐ Outward Bound Hong Kong<br>香港外展訓練學校 |
| | ☐ Visual Examination Form for Admission to Care and Attention Home for the Aged Blind |
| | ☐ Application for change of sex entry on Hong Kong identity cards - Medical Certificate<br>申請更改香港身份證上性別記項 - 醫學證明 |

| | |
|---|---|
| (c) Mode of collection:<br>領取方式 | ☐ In person<br>親身領取　　　　☐ By registered mail<br>以掛號郵件收取 |

3. **Payment method:**
   **付款方法**

   ☐ By cash / ePayment / credit card at the shroff office in person
   　　親臨繳費處以現金 / 電子方式 / 信用卡付款

   ☐ By crossed cheque made payable to "Hospital Authority"　Cheque number
   　　以抬頭為「醫院管理局」的劃線支票付款　　　　　　　　支票號碼　_____

4. **Person to whom the medical certification is to be sent**
   **醫療資料的接收人**

   The Patient and/or the Patient's parent / guardian by signing this Form consents to the relevant HA hospital disclosing and sending the medical certification to the following person:
   病人及/或其父 / 母 / 監護人簽署此表格代表病人及/或其父 / 母 / 監護人同意有關之醫院管理局醫院向下述人士透露及發出其醫療資料

   (a) Name (English)　　　　　　　　　　　(Chinese)
   　　姓名 (英文)　　　　　　　　　　　　　(中文)

   (b) HKID Card No.　　　　　　　　／　Passport No.
   　　香港身份證號碼　　　　　　　　　　護照號碼

   (c) Address
   　　地址　　_____

   (d) Telephone No.
   　　聯絡電話號碼　_____

   (e) Email address
   　　電郵地址　_____

   *Please produce in person the original or provide a true copy of the identity document of the individual to whom the medical certification is to be sent (if not the patient).*
   *如果此醫療資料非由病人本人接收，請親身出示接收人的身份證明文件或提交真確副本。*

5. **Particulars of patient's parent / guardian:**　　*(for patient under 18 years old or legal guardian)*
   **病人父 / 母 / 監護人資料**　　　　　　　*(適用於未滿十八歲 或 有監護人的病人)*

   (a) Name (English)　　　　　　　　　　　(Chinese)
   　　姓名 (英文)　_____　(中文)　_____

   (b) HKID card number　　　　　　Passport number
   　　香港身份證號碼　_____／　護照號碼　_____

   (c) Address
   　　地址　_____

   (d) Telephone number
   　　聯絡電話號碼　_____

   (e) Relationship with patient
   　　與病人關係　_____

   (f) Email address
   　　電郵地址　_____

   *Please produce in person the original or provide a true copy of the identity document of patient's parent / guardian.*
   *請親身出示病人父 / 母 / 監護人的身份證明文件正本或提交真確副本。*

   *Please also attach a true copy of the documentary evidence to support the relationship between parent / guardian and the patient.*
   *請一併附上能證明病人父 / 母 / 監護人與病人之關係的證明文件真確副本。*

6. **Declaration and signatures:**
   **聲明及簽署**

   The patient and (where applicable) patient's parent / guardian declare that the information given in this medical certification application form is accurate
   病人及病人父 / 母 / 監護人 (如適用者) 謹此聲明在本「醫療證明書申請表」內提供的資料準確無訛。

   Signature　　　　　　　　　　　　　　　　　　Date (dd/mm/yyyy)
   病人簽署　_____　　　日期 (日/月/年)　_____

   **If application by patient's parent / guardian:**
   **若由病人父 / 母 / 監護人提交申請**

   Signature of patient's
   parent / guardian　　　　　　　　　　　　　Date (dd/mm/yyyy)
   病人父 / 母 / 監護人簽署　_____　日期 (日/月/年)　_____

# Notes for application
# 申請須知

1. The charge is $300 per medical certification per specialty (applicable to designated forms listed on the application form only)
   每份醫療證明書每個專科收費為 300 元 (只限本申請表內列明之表格)。

2. Application made by relevant person should obtain patient's written consent.
   有關人士須取得病人的書面同意，方可申請。

3. Applicant and concerned parties should present all relevant documents for record and verification of identity. The documents include:
   申請人及有關人士必須出示下列有關證明文件，以資紀錄及核實身份，文件包括：

   3.1 If the HKID card number is provided, no copy or physical production of the HKID card is required in case the number provided is accurate and corresponds to the number recorded on HA's database.   If not, a true copy of the HKID card will be required for verification.   Alternatively, the HKID card may be physically produced for verification at our hospital.
       若提交香港身份證號碼，而提交的號碼正確及與醫管局資料庫所記錄的號碼相符，無須親身出示香港身份證正本或提交真確副本。否則，須提交香港身份證的真確副本，或親身向本院出示香港身份證正本，以供查核。

   3.2 If the patient is under 18:   Birth certificate **or** legal custody paper **AND** parent / guardian's written consent (if application made by relevant person) and attach a copy of documentary evidence to support the relationship with the data subject.
       若病人在十八歲以下：出生證明書 **或** 法定管養權證明書 **及** 父/母/監護人之書面同意(適用於由有關人士提出申請)，並附上與資料當事人關係的證明文件副本。

   3.3 A court document issued by courts in Hong Kong appointing the relevant person to manage the affairs of the patient (if applicable)
       香港法院簽發任命有關人士管理病人事務的法院文件（如適用）

4. The designated form has to be submitted together with the application form. Please fill in the application form carefully. Insufficient or inaccurate information will lead to delay or rejection.
   請將該指定表格連同申請表一併交回。請清楚填妥申請表內每一項資料。若所填資料有不足或錯誤，此項申請將受到延誤或拒絕。

5. The applicant should settle the fee at the **Shroff Office** upon submission of the application form. Payment by cheque should be crossed and made payable to the "**Hospital Authority**".
   遞交醫療證明書申請表時，申請人須到**繳費處**繳交費用。如以支票付款，抬頭請寫「**醫院管理局**」，並加劃線。

6. For application by post, send the duly completed application form together with a crossed cheque made payable to "**Hospital Authority**" to:
   如以郵遞方式申請，請將填妥表格連同劃線支票，抬頭請寫「**醫院管理局**」，並寄回：

   > Health Information and Records Department at 1/F, Kwai Chung Hospital
   > Day Recovery Centre, 3-15 Kwai Chung Hospital Road, New Territories
   > 新界葵涌醫院路 3-15 號 葵涌醫院日間復元中心 1 樓 醫療資訊及紀錄部

7. Please do not send cash by post.
   切勿郵寄現金。

8. No refund will be made even the application is withdrawn before the medical certificate is issued.
   申請人即使在醫療證明書發出前撤銷申請，已繳費用，概不發還。

9. In general, each medical certification application will be completed in around 8 weeks.
   一般情況下，每份醫療證明書申請需時約 8 星期才能完成。

10. Each medical certification is written in English only.
    每份醫療證明書均只用英文書寫。

11. Should you have any queries, please feel free to contact our Health Information and Records Department.
    如有任何查詢，請聯絡本院醫療資訊及紀錄部。

    Tel 電話: 2959 8028          Fax 傳真: 2307 6521          Email 電郵: kch.enquiry@ha.org.hk