



Hong Kong Society of Interventional Radiology Ltd.

香港介入放射科醫學會有限公司

Membership Application Form

Name (Please type or print)

(English): (Prof. Dr. Mr. Mrs. Ms.) _____

(Chinese): _____ Sex: M F

Position/Occupation: _____

Institute: _____

Correspondence Address: _____

Telephone No.: _____ **Fax No.:** _____ **E-mail Address:** _____

Status in the Hong Kong College of Radiologists:

Fellow Member Associate Member Trainee Member Non-member

Type of Membership*:

<input type="checkbox"/> Member	Annual Subscription Fee HK\$150 (waived for the current year)
<input type="checkbox"/> Associate Member	HK\$100 (waived for the current year)

* Any person being:-

- (i) a medical practitioner registered or deemed to be registered under the Medical Registration Ordinance (Cap.161); and
- (ii) is engaged in the practice of interventional radiology; and
- (iii) is a member or a fellow of the Hong Kong College of Radiologists

shall be eligible to be a Member

Special fields of interest: _____

Application for FREE LIFE MEMBERSHIP of Asia-Pacific Society of Cardiovascular And Interventional Radiology (APSCVIR): YES NO

(Your name, corresponding address and e-mail address will be sent to APSCVIR. Information of subsequent meetings and membership benefits will be sent to you through e-mail)

Personal Information Collection Statement

- The information provided by me will be used for purposes relating to the application for membership registration.
- The Hong Kong Society of Interventional Radiology Ltd. may give all or some of the information to other parties authorized by law to receive it.
- Subject to exemptions under the Personal Data (Privacy) Ordinance, I have a right of access and correction with respect to personal data.
- The personal data provided by means of this form shall be used by the Hong Kong Society of Interventional Radiology Ltd. for processing of my application and to facilitate communication between the Hong Kong Society of Interventional Radiology Ltd. and myself.
- Further, I hereby consent do not consent to the release of my personal correspondence with the Hong Kong Society of Interventional Radiology Ltd. to other Interventional Radiology related bodies.

Signature of applicant

Date

Please return the completed registration form by mail or fax to,

Ms H Y N G.

IF, Department of Radiology, Kwong Wah Hospital, 25 Waterloo Road, Kowloon

Fax: 3517-5454

For official use only

Form received: _____

Registration No.: _____