

**Membership Application / Renewal Form  
(for the year 2017)**

**Personal Information**

Name in English (as appeared on HKID card): \_\_\_\_\_ Name in Chinese: \_\_\_\_\_

Gender:  Male  Female

Types of Membership:  Ordinary  Associate  Corporate

Profession:  Doctor  Nurse  Allied Health  Others: \_\_\_\_\_

**Specialties / Disciplines:**

- |                                       |   |                                    |  |
|---------------------------------------|---|------------------------------------|--|
| <input type="radio"/> Anesthesiology  | <input type="radio"/> Clinical Oncology       | <input type="radio"/> Dental       | <input type="radio"/> Family Medicine / General Practice |
| <input type="radio"/> Neurology       | <input type="radio"/> Neurosurgery            | <input type="radio"/> Orthopaedics | <input type="radio"/> Palliative Medicine                |
| <input type="radio"/> Psychiatry      | <input type="radio"/> Rehabilitation Medicine | <input type="radio"/> Rheumatology | <input type="radio"/> Clinical Psychologist              |
| <input type="radio"/> Physiotherapist | <input type="radio"/> Occupational Therapist  | <input type="radio"/> Surgeon      | <input type="radio"/> Others: _____                      |

Current Appointment: \_\_\_\_\_

Correspondence Address: (In Block Letter)  
\_\_\_\_\_  
\_\_\_\_\_

Phone: Office: \_\_\_\_\_ Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Relevant Professional & Academic Qualifications**

Year	Award	Institution	Country

**Membership Fee (Membership fee is renewed annually. Membership year is from 1 January to 31 December)**

Ordinary	HK\$300
Associate	HK\$50
Corporate	HK\$5,000

Cheque No.: \_\_\_\_\_ Issuing Bank: \_\_\_\_\_

Payments should be made with "PERSONAL CHEQUE ONLY" payable to "Hong Kong Society of Musculoskeletal Pain" with your name and contact telephone number on the back of the cheque.

Send the completed form and cheque to "Honorary Secretary, Hong Kong Society of Musculoskeletal Pain, P.O.Box. No.98530, Tsim Sha Tsui Post Office, Kowloon".

**Declaration (Only applicable for Ordinary and Association Members)**

- I declare that I am a resident of Hong Kong.
- I declare that I am qualified to practice in my healthcare discipline.
- I declare that the above information and all substantial documents are true and correct.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_