

填妥此表格後(第一至五頁) ，請電郵：[mail.qhna@qhs.com.hk](mailto:mail.qhna@qhs.com.hk) 或  
傳真 2951-6239 或 WhatsApp 5505-9983 / 9172-9062 傳送到卓健護  
理介紹所，我們將會安排預約登記。

Please fill in this form(P.6-8) and return to QHNA by email :  
[mail.qhna@qhs.com.hk](mailto:mail.qhna@qhs.com.hk) or fax 2951-6239 or WhatsApp 5505-9983 / 9172-9062.  
We will invite you to interview.

If you have any enquiry, please call Ms Ma 2975-2392 or Ms Lam 2975-2646.

Remarks: You could fill in the form with Adobe Reader

**REGISTRATION FORM**  
  
**FOR**  
**HEALTHCARE PROFESSIONALS PLACEMENT**  
  
**AS INDEPENDENT CONTRACTORS**

To register your availability for nurse / care assistant placement as an independent contractor, please carefully read and complete the enclosed documents including:

- (1) Registration Form (pages 2 - 5)
- (2) Independent Contractor's Placement Agreement (pages 6 - 9)

1. PLEASE COMPLETE & RETURN THIS FORM AFTER READING THE ATTACHED "SERVICE STANDARDS OF INDEPENDENT CONTRACTORS" &
2. PLEASE RETAIN A COPY OF THE ATTACHED "INDEPENDENT CONTRACTOR'S PLACEMENT AGREEMENT"

**PERSONAL DETAILS**

Please  **Rank**

<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Enrolled Nurse	<input type="checkbox"/> Chinese Trained Nurse	<input type="checkbox"/> Care Related Support Worker
<input type="checkbox"/> Health Care Assistant	<input type="checkbox"/> Health Worker	<input type="checkbox"/> Personal Care Worker	<input type="checkbox"/> Care Worker
<input type="checkbox"/> Others : Describe _____			

Surname (Chinese) :	Surname (English) :
First Name (Chinese) :	First Name (English) :
HKID Card No. :	
Address :	
Home Phone :	
Pager / Mobile :	
E-mail Address :	
Place of Birth :	
Date of Birth:	
Age :	
Nationality:	
Sex:	
Height (cm) :	
Weight (kg) :	
3M N95 Mask Model :	<input type="checkbox"/> 1860s <input type="checkbox"/> 1860 <input type="checkbox"/> 1870+ other:

Have you ever been professionally diagnosed with any Physical or Psychiatric illness?		If yes, describe:	
Marital Status :			
Children (no. and age)			
Do you have a criminal record?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, describe:	
Do you have a sexual conviction record?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, describe:	
Languages: <i>Cantonese</i>	Spoken: Little <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Written: Little <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/>		
Languages: <i>English</i>	Spoken: Little <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Written: Little <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/>		
Languages: <i>Mandarin</i>	Spoken: Little <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Written: Little <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/>		
Are you a member of any other nursing agency?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, please give the name.	
How did you hear of QHNA?	Advertising <input type="checkbox"/> Friend <input type="checkbox"/> Hospital <input type="checkbox"/> Website <input type="checkbox"/>	Others : Describe:	

**PROFESSIONAL QUALIFICATIONS**

Graduation Hospital / School / Institution Name	Date	Qualification	Reg. No.

**FOR RECEIVING SERVICE FEE**

Receiving Service Fee Account	Bank Name	Bank Account Owner	Bank A/C no.

**REFERENCES / JOB EXPERIENCE**

Referee's name		Tel no.	
Emergency contact person		Tel no.	

Work experience (including inland and Hong Kong)	Location (hospital/company and address)	From(month/year) to (month/year)	Position
A & E			
Medical			
Surgical			
Orthopaedic			
Paediatric			
Renal			
Obstetric			
Oncology			
ICU			
Paediatric ICU			
Elderly Care			
Psychiatric			
Endoscopy			
Theatre			
Mentally Retarded			
Teaching			
Others (Describe)			

<b>Special skills (Please tick)</b>	IV Insertion	<input type="checkbox"/>	Ventilator	<input type="checkbox"/>
	Blood taking	<input type="checkbox"/>	BiPAP	<input type="checkbox"/>
	Haemodialysis	<input type="checkbox"/>	Peritoneal dialysis	<input type="checkbox"/>
	BLS/ACLS Cert	<input type="checkbox"/>		

**Vaccination and Medical Checkup Record**

Independent Contractor shall promptly submit copies of all the examination / test results / vaccination records as required. **If there are any changes, please inform Quality Healthcare Nursing Agency to update your record.**

X-ray Examination	Please <input checked="" type="checkbox"/> if appropriate		Remarks / Date / Record
	Yes	No	
No more than one year before the duty starts			

Vaccination Record	Please <input checked="" type="checkbox"/> if appropriate		Remarks / Date / Record
	Yes	No	
Hepatitis B Vaccine			
MMR (Measles, Mumps & Rubella) Vaccine			
Chickenpox Vaccine			
Other Test (pls specify):			

Vaccination Suggestion:	Dose
Hepatitis B status if negative please have:	<input type="checkbox"/> Primary course: THREE shots (0-1-6) <input type="checkbox"/> Booster dose: Hepatitis B Vaccination or <input type="checkbox"/> Booster course: THREE shots (0-1-2)
MMR (Measles, Mumps & Rubella) if not vaccinated please have:	<input type="checkbox"/> 2 shots for those without any MMR vaccination before given at 0,1 month 首次接種MMR <input type="checkbox"/> 1 shot for those who have received 1 dose of MMR before
Chickenpox status if negative please have:	<input type="checkbox"/> 2 Shots (0-2) if Varicella Zoster Virus IgG is negative <input type="checkbox"/> Booster dose: 1 shot for workers in high risk ward e.g. Paediatrics, Obstetrics & Gynaecology, Haematology, Oncology, Bone marrow transplants Infectious disease Unit / Isolation Ward, Department of Accident and Emergency

*"I hereby give my consent to Quality HealthCare Nursing Agency Limited ("QHNA") to access and transfer to the Hospital Authority or any third party my medical information supplied herein as QHNA may in its absolute discretion deem necessary and for such purposes as QHNA may deem fit."*

Signature:

\_\_\_\_\_  
Nurse/Carer Name:

Date: