

香港腦科學會

The Hong Kong Neurological Society

Hong Kong Registered Charitable Organization, IRD Ref: 91/8121

Application for Full Membership of The Hong Kong Neurological Society

Name: Office Address:	in Chinese:	Sex/Age:
Home Address:		70
Mobile No.:	Fax:	
Office Telephone:	Email Address:	
*As required by HKNS constitution, appl	icant has to be nominated by at least two f	ull members
Qualification	Institution	Date
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Present Practice	and the second s	
1. Private Practice	Mainly General Medicine General Medicine + Neurology	
2. Hospital Authority3. University	2. General Medici 3. Mainly Neurolo	0.
4. Others, specify	4. Neurology Nurs	~.
T. Culeis, specify	5. Others, specify	
 	Experience	
Unit	Post	Date
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	Publications	
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Date of Application:	Signature:	
Date of Application:	Nomination	
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Date of Application:	Nomination	
Date of Application: Name of 1 st Nominator:	Nomination Name of 2 nd Nominate Signature of Nominate	
Date of Application: Name of 1 st Nominator: Signature of Nominator:	Nomination Name of 2 nd Nominate Signature of Nominate Official Use	or:
Date of Application: Name of 1 st Nominator:	Nomination Name of 2 nd Nominate Signature of Nominate Official Use	or: