



Enrolment in Primary Care Directory (PCD) via PCD Platform



[PCD Platform](#)



* Are you a primary care provider of the following type?

- Dentist
- Occupational Therapist
- Physiotherapist

Yes No


* What is/are your type of practice?

- Hospital Authority
- Non-governmental Organisation
- Private
- University

eHR UID is essential
for application.

* indicates mandatory.

Information

 Having created a valid Healthcare Professional (HCPProf) account under eHealth is one of the entry requirements for dentists, OTs and PTs to enrol in the Primary Care Directory (the Directory). Before you begin filling in your application, please ensure you have your eHR UID readily available. This information is required to complete your application process.

If you understand the above requirement and want to continue with your application, please click "Continue".

Please ensure your eHR UID is ready and click "Continue" to proceed to your application.

HKIC copy is essential for verification of your identity.

2 You have to provide HKIC copy for verification purpose, either upload of soft copy during online enrolment; or by fax or post to the PHCC within one week.

1. Fill in All the information Conduct / Disc

3. Terms and Conditions 4. Completion
to the Primary Care Directory. Please provide information

* indicates mandatory.

* Personal Particulars * Professional Information * Qualification Information * Practice Information Others

* HKIC No. (Will not be disclosed to the public) [] [] ([])
 Submission of HKIC copy
 Upload softcopy now [] [Select ...]
 Will submit by fax or post to Primary Healthcare Commission

* Name on HKIC ? Surname [] First Name [] (in English) [] (in Chinese) []
 Also Known As ? Surname [] First Name [] (in English) [] (in Chinese) []
 Gender -- Please Select -- Photo [Select ...]
 * Email ? []
 * Confirm Email []
 Please check the box if you agree to display your email address to the public.
 * Mobile Phone No. ? (Will not be disclosed to the public) +852 []
 I do not wish to receive SMS about the operation of Primary Care Directory sent by the Primary Healthcare Commission.
 Daytime Contact Telephone No. ? (Will not be disclosed to the public) []
 Pager ? [] Page []
 Please check the box if you agree to display your pager no. to the public.
 * Correspondence Address (in English) (Will not be disclosed to the public) -- Please Select Region -- []
 -- Please Select District -- [] -- Please Select Sub District -- []
 [] , Sub District, District, Region
 * eHR UID ? []

1 Input personal particulars. You may click the icon ? to read the input tips of the relevant field.

3 You may upload a recent passport-type photograph to be displayed in PCD by clicking the "Select" button.

4 Provide a correspondence address for communication. This address will not be disclosed to the public.

6 Click "Next" to proceed to "Professional Information" section.

5 You are required to provide your eHR UID.

? Need help?

< Back > Next

▶▶▶ 1. Fill in the Form

2. Confirm Details

3. Terms and Conditions

4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

[← Back](#) [Next →](#)

* Personal Particulars * Professional Information Qualification Information * Practice Information

* indicates mandatory.

Occupational Therapist X + Add Profession

* Registration No. ?

* eHR UID ?

1234567890

7

Input your registration no.
Your eHR UID is filled
automatically.

? [Need help?](#)

[← Back](#) [Next →](#)

8

Click "Next" to proceed
to "Qualification
Information" section.

▶▶▶ 1. Fill in the Form 2. Confirm Details 3. Terms and Conditions 4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

< Back Next >

* indicates mandatory.

* Personal Particulars * Professional Information **Qualification Information** * Practice Information

Occupational Therapist

Select Qualification View Full List

According to the "[Code of Practice for Registered Occupational Therapists](#)" issued by the Occupational Therapists Board (OTB), a qualification entered in the List of Quotable Qualifications of the OTB may be quoted by an Occupational Therapist possessing that qualification. Please refer to the "[List of Quotable Qualifications](#)" available on the OTB's website when quoting qualifications in the Directory.

Type	Qualification

Continuing Education / Professional Development Currently participating in the Continuing Professional Development (CPD) Scheme for Registered Occupational Therapists of the Occupational Therapists Board (OTB) and complied with the requirements determined by the OTB. to

< Back Next >

9 Select qualification by typing keywords in the text box or choosing from "View Full List".

10 Click "Next" to proceed.

[? Need help?](#)

▶▶▶ 1. Fill in the Form 2. Confirm Details 3. Terms and Conditions 4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

[Back](#) [Next](#)

* Personal Particulars * Professional Information Qualification Information * Practice Information

* indicates mandatory.

+ Add Practice

* Type of Primary Care Provider Occupational Therapist
* Type of Practice Hospital Authority Non-governmental Organisation Private University

[? Need help?](#)

[Back](#) [Next](#)

11

Select "Type of Practice".

12

Click "Next" to proceed.

▶▶▶ 1. Fill in the Form 2. Confirm Details 3. Terms and Conditions 4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

[Back](#) [Next](#)

* Personal Particulars * Professional Information Qualification Information * Practice Information

* indicates mandatory.

Practice 1 X + Add Practice

* Type of Primary Care Provider Occupational Therapist

* Type Private

* General Information Opening Hours Service Provision & Fee Other Information

Practice Name (in English)

(in Chinese)

* Practice Address [Please Input Practice](#)

* Contact Number Telephone Emergency Contact Number Fax

I declare that documentation system (in electronic or physical form) and other practice information (including those related to referrals) for the above practice location.

13

Click "Please Input Practice" to input your practice address.

[Need help?](#)

[Back](#) [Next](#)

▶▶▶ 1. Fill in the Form 2. Confirm Details 3. Terms and Conditions 4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

[Back](#) [Next](#)

*Personal Particulars *Professional Information Qualification Information *Practice Information

* indicates mandatory.

Practice 1 X + Add Practice

* Type of Primary Care Provider Occupational Therapist

* Type Private

*General Information Opening Hours Service Provision & Fee Other **Address Confirmation**

Practice Name

* Practice Address

(in English)

Room/Flat

Building

Estate

Street No.

Region

(in Traditional Chinese)

Room/Flat

Building

Estate

Street No.

Region

[To Convert Practice Address](#)

* Contact Number

Telephone

Emergency Contact Number

Fax

I declare that documentation system (in electronic or physical form) is in place to record patients' information (including those related to referrals) for the above practice location.

[Need help?](#)

[Back](#) [Next](#)

14

Input your practice address

Room/Flat e.g. 501, 25A Floor 11/F Block e.g. 2, A

Building THE HUB

Estate Name of Estate

Street No. 23 Street/Road YIP KAN STREET

Region HONG KONG District SOUTHERN DISTRICT Sub District -- Please Select Sub District --

[Search](#)

[Cancel](#)

15

Click "Search" to generate address(es) for selection.

▶▶▶ 1. Fill in the Form 2. Confirm Details 3. Terms and Conditions 4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

[Back](#) [Next](#)

* Personal Particulars * Professional Information Qualification Information * Practice Information

* indicates mandatory.

Practice 1 X [+ Add Practice](#)

* Type of Primary Care Provider Occupational Therapist

* Type Private

* General Information Opening Hours Service Provider

Practice Name

* Practice Address

(in English)

Room/Flat

16

Select the matched address

(in Traditional Chinese)

Room/Flat

Building

Estate

Street No.

Region

[To Convert Practice Address](#)

* Contact Number

Telephone

Emergency Contact Number

Fax

17

Click "Confirm Selection".

I declare that documentation system (in electronic or physical form) is in place to record patients' information (including those related to the practice).

Address Confirmation

Room/Flat Floor Block

Building

Estate

Street No. Street/Road

Region District Sub District

[Search](#)

Please select practice address from below

	Matched Address (in English)	Matched Address (in Chinese)
<input checked="" type="radio"/>	THE HUB, 23 YIP KAN STREET, SOUTHERN DISTRICT, HONG KONG	香港南區業勤街23號THE HUB

Page 1 of 1 (1 items)

[Cancel](#) [Confirm Selection](#) [No Matched Record](#)

[Need help?](#)

[Back](#) [Next](#)

▶▶▶ 1. Fill in the Form 2. Confirm Details 3. Terms and Conditions 4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

[Back](#) [Next](#)

* Personal Particulars * Professional Information Qualification Information * Practice Information

* indicates mandatory.

Practice 1 X [+ Add Practice](#)

* Type of Primary Care Provider Occupational Therapist

* Type Private

* General Information Opening Hours Service Provision & Fee Other Information

Practice Name (in English)

(in Chinese)

* Practice Address (in English)

Room/Flat	<input type="text"/> e.g. 501, 25A	Floor	<input type="text"/> 11/F	Block	
Building	THE HUB				
Estate					
Street No.	23	Street/Road	YIP KAN STREET		
Region	HONG KONG	District	SOUTHERN DISTRICT	Sub District	-- Please Select Sub District --

(in Traditional Chinese)

Room/Flat	<input type="text"/> e.g. 501, 25A	F	<input type="text"/> 11/F	Block	
Building	THE HUB				
Estate					
Street No.	23	Street/Road	業勤街		
Region	香港	District	南區	Sub District	-- 請選擇分地區 --

[To Convert Practice Address](#)

* Contact Number Telephone 92345678 Emergency Contact Number Fax

I declare that documentation system (in electronic or physical form) is in place to record patients' information (including those related to referrals) for the above practice location.

18
Input contact no. of practice location.

20
Click "Next" to proceed

19
Check the box to declare that documentation system is in place for the practice location

[Need help?](#)

[Back](#) [Next](#)

▶▶▶ 1. Fill in the Form 2. Confirm Details 3. Terms and Conditions 4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

[Back](#) [Next](#)

* Personal Particulars * Professional Information Qualification Information * Practice Information

* indicates mandatory.

Practice 1 X + Add Practice

* Type of Primary Care Provider Occupational Therapist

* Type Private

* General Information **Opening Hours** Service Provision & Fee Other Information

Regular

Start Date	End Date	Timeslot 1	Timeslot 2	Timeslot 3		
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>	<input type="checkbox"/> 24 Hours	* Remove

If service is provided on public holidays, please input the service hours under "Special Arrangement".

By Appointment

[+ Add](#)

Special Arrangement

Start Date	End Date		Timeslot 1	Timeslot 2	Timeslot 3	
<input type="text"/>	<input type="text"/>	-- Please Select --	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>	* Remove

Service provided by other Occupational Therapist

[+ Add Public Holiday](#)

[+ Add](#)

21
Input opening hours.

22
Click "Next" to proceed

[Need help?](#)

[Back](#) [Next](#)

▶▶▶ 1. Fill in the Form 2. Confirm Details 3. Terms and Conditions 4. Completion

All the information provided below (except otherwise indicated) will be uploaded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.

[Back](#) [Next](#)

* Personal Particulars * Professional Information Qualification Information * Practice Information

* indicates mandatory.

Practice 1 + Add Practice

* Type of Primary Care Provider **Occupational Therapist**

* Type **Private**

* General Information Opening Hours Service Provision & Fee Other Information

Government Primary Care
Enhancement Programme

Your enrolment status in government primary care enhancement programme(s) will be added to the Directory by the Primary Healthcare Commission.

Payment Method [Select ...](#)

Basic Consultation Fee \$ From - \$ To

24
Click "Next" to proceed

23
You may select payment method and input basic consultation fee.

[Back](#) [Next](#)

[Need help?](#)

▶▶▶ 1. Fill in the Form

All the information provided below Practice of your profession.

26

If you have more than one practice location, click here to add other practice(s)

3. Terms and Conditions

4. Completion

ded to the Primary Care Directory. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline /

< Back > Next

* Personal Particulars * Practice Information * indicates mandatory.

Practice 1 X + Add Practice

* Type of Primary Care Provider Occupational Therapist

* Type Private

* General Information Opening Hours Service Provision & Fee Other Information

Language / Dialect Spoken

Primary Care Team Members

You may select your Primary Care Team Members who are located in the same practice address as yours and/ or who are not located in the same practice address.

Same Practice Address <input type="button" value="Select ..."/>	Not in the Same Practice Address <input type="button" value="Select ..."/>

Barrier Free Facilities

[? Need help?](#)

< Back > Next

25

You may provide other information.

27

Click "Next" to proceed

1. Fill in the Form

2. Confirm Details

3. Terms and Conditions

4. Completion

[Edit Personal Particulars](#)

[Edit Professional Information](#)

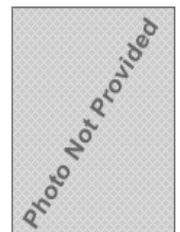
[Edit Qualification Information](#)

[Edit Practice Information](#)

i Please confirm your information provided.

28

Confirm the information and click “Edit” to make changes as appropriate. All the practice information provided in the application (except otherwise indicated) will be uploaded to the Directory for viewing by the public once enrolment is approved. Please provide information which is true, correct and in compliance with the Code of Conduct / Discipline / Practice of your profession.



Personal Particulars

HKIC No. **	XXXXXXX
Name in English (Also Known As)	CHAN, TAI MAN (Not provided)
Name in Chinese (Also Known As)	Not provided (Not provided)
Gender	Male
Email **	XXX@XXX.com
Mobile Phone No. **	+852 92345678
Daytime Contact Telephone No. **	92345678
Pager **	Not provided
Correspondence Address **	11/F, THE HUB, WONG CHUK I
eHR UID **	1234567890

** Will not be disclosed to public

Professional Information

Occupational Therapist [1 Practice(s)]

Registration No.	OT123456
Qualification	• Bachelor of Science (Honours) in Occupational Therapy of The Hong Kong Polytechnic University [2018]
Continuing Education / Professional Development	Not provided

Practice Information

Details							
1	<p>General Information</p> <table border="1"> <tr> <td>Type of Practice</td> <td>Private</td> </tr> <tr> <td>Practice Name</td> <td>Not provided</td> </tr> <tr> <td>Practice Address</td> <td>11/F THE HUB, 23 YIP KAN STREET, SOUTHERN DISTRICT, HONG KONG</td> </tr> </table>	Type of Practice	Private	Practice Name	Not provided	Practice Address	11/F THE HUB, 23 YIP KAN STREET, SOUTHERN DISTRICT, HONG KONG
Type of Practice	Private						
Practice Name	Not provided						
Practice Address	11/F THE HUB, 23 YIP KAN STREET, SOUTHERN DISTRICT, HONG KONG						

1. Fill in the Form

2. Confirm Details

▶▶▶ 3. Terms and Conditions

4. Completion

Terms and Conditions

1. Eligibility criteria for enrolment

1.1 To enrol in the Primary Care Directory ("Directory") as a healthcare service provider ("Enrolled Healthcare Service Provider"), an applicant ("Applicant") must:

(a) commit to providing accessible, comprehensive, continuing and co-ordinated person-centred primary healthcare services; and

(b) be any of the following categories:

(i) a "registered medical practitioner" within the meaning of section 2 of the Medical Registration Ordinance (Cap. 161) ("MRO") who holds a valid practising certificate issued pursuant to that Ordinance ("registered medical practitioner");

29

Click the checkbox after reading and agreeing to the Terms and Conditions

(ii) a "registered dentist" within the meaning of section 2 of the Dentists Registration Ordinance (Cap. 156) ("DRO") who:

holds a valid practising certificate issued pursuant to that Ordinance ("registered dentist"); and

has a professional ("HCPProf") account under the Electronic Health Record Sharing System ("eHealth")

(iii) a "registered Chinese medicine practitioner" within the meaning of section 2 of the Chinese Medicine Ordinance (Cap. 549) ("CMO") who holds a valid practising certificate issued pursuant to that Ordinance ("registered Chinese medicine practitioner");

I have read and agree to the Terms and Conditions

< Back

> Submit

30

Click

> Submit