HONG KONG COLLEGE OF MIDWIVES (HKCMW)

ACCREDITATION OF CLINICAL TRAINING SITES FOR FELLOW MEMBERSHIP TRAINING

APPLICATION FORM

NAME OF TRAINING SITE: _____

SUB-SPECIALTY TRAINING FOR: _____

Contact Person: _____

Rank / Position: _____

Contact Phone No.: _____

Email address: _____

Date of Application: _____

Has been accredited as clinical training site for Midwives Registration by the Midwives Council of Hong Kong (MWCHK): *NO / YES, valid period _____

1. Clinical Establishment

a.	Ambulatory Care Center	*YES / NO
b.	Clinic:	
	Midwife Clinic	*YES / NO
	Obstetric Clinic	*YES / NO
	Lactation Clinic	*YES / NO
	Prenatal Diagnostic Clinic	*YES / NO
c.	Antenatal Ward	No. of beds _____
d.	Delivery Suite	No. of beds _____
e.	Maternity High Dependency Care	No. of beds _____
f.	Postnatal Ward	No. of beds _____
g.	Neonatal Unit:	
	NICU	*YES / NO
	SCBU	*YES / NO

(*please circle as appropriate)

2. Staff Establishment

Registered midwives working in the training maternity unit:

Rank	Number
_____	_____
_____	_____
_____	_____
_____	_____

3. Training Resources

3.1 Personnel providing clinical training

A. No. of clinical mentors for general midwifery training: _____

(NA if not accredited training site by the MWCHK)

B. No. of HKCMW clinical mentors:

i) No. of HKCMW clinical mentors (advance midwifery practice) i) _____

ii) No. of HKCMW specialist mentors

a) Lactation ii a)_____

b) Midwife-led Care ii b)_____

c) Midwifery Ultrasound (Prenatal Screening and Counselling) ii c)_____

d) High Dependency Midwifery Care ii d)_____

C. No. of HKCMW Fellow Members: _____

3.2 Learning resources (the related documents shall be examined during the on-site visit)

A. Clinical guidelines and protocols in various training areas *YES / NO

B. Clinical log book *YES / NO

C. Learning resource center / library *YES / NO

D. Others:

(*please circle as appropriate)

4. Workload Statistics

4.1 Average daily attendance in clinic : _____

4.2 Total number of Maternity beds (excluding delivery suite): _____

4.3 Average occupancy rate: _____

4.4 Total no. of deliveries in the 12 months preceding the accreditation visit: _____

		Number	Percentage
a.	Normal delivery	_____	_____
b.	Instrumental delivery:		
	Vacuum extraction	_____	_____
	Forceps delivery	_____	_____
c.	Caesarean section	_____	_____

5. Service Provision by the Unit

5.1 Lactation service / care ***YES / NO**

(If yes, please list out the type of service / care provided)

_____

_____

_____

_____

5.2 Midwife-led service / care ***YES / NO**

(If yes, please list out the type of service / care provided)

_____

_____

_____

_____

_____

(*please circle as appropriate)

5.3 Prenatal Screening and Counseling Midwife Service ***YES / NO**

(If yes, please list out the type of service / care provided)

_____

_____

_____

_____

_____

5.4 High Dependency Midwifery Care Service ***YES / NO**

(If yes, please list out the type of service / care provided)

_____

_____

_____

_____

_____

(*please circle as appropriate)

6. Professional Training & Development

6.1 Does the training unit require the staff to have Post-registration Education in Midwifery (PEM)? *YES / NO

If yes, please indicate the average PEM points obtained per staff in the last 12 months

_____

6.2 Does the training unit provide continuing midwifery education / in-service training for staff? *YES / NO

If yes, please list the programs / courses provided:

_____

_____

_____

_____

_____

_____

--- END ---