



2021 Prize for Best Original Research by Trainees

ABSTRACT FORM

Principal Investigator

Surname*:			Name in Chinese:	
Forename*:			MCHK/DCHK no.*:	

Institution*:	
Department*:	

Correspondence address*:			
Contact tel. no.*:		Contact fax no.:	
Email address*:			

You are a trainee of the College of (tick ✓)*:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anaesthesiologists | <input type="checkbox"/> Community Medicine | <input type="checkbox"/> Dental Surgeons |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Obst. & Gynaecologists |
| <input type="checkbox"/> Ophthalmologists | <input type="checkbox"/> Orthopaedic Surgeons | <input type="checkbox"/> Otorhinolaryngologists |
| <input type="checkbox"/> Paediatricians | <input type="checkbox"/> Pathologists | <input type="checkbox"/> Physicians |
| <input type="checkbox"/> Psychiatrists | <input type="checkbox"/> Radiologists | <input type="checkbox"/> Surgeons |

*Fields marked with * are required.*

Declaration

I hereby declare that I am the principal investigator of the research submitted.

Signature : _____ Date : _____

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