



**College of Nursing, Hong Kong**  
12/F & 13/F , Hyde Centre, 221 Gloucester Road, Wanchai, Hong Kong  
Tel: 2572 9255 Fax: 2838 6280  
Email: info@cnhk.org.hk

**Application No.** \_\_\_\_\_

**CLINICAL NURSE SPECIALIST**  
**Application for Re-Accreditation**

Name: \_\_\_\_\_ (Dr. Mrs., Mr., Ms., Miss)\*  
Surname                      Other names                      Name in Chinese

HKID Card No.: \_\_\_\_\_

Tel No. (H) : \_\_\_\_\_ Tel No. (O) : \_\_\_\_\_

Mobile No. : \_\_\_\_\_ Fax No. : \_\_\_\_\_

Email Address : \_\_\_\_\_

Correspondence Address: \_\_\_\_\_

\_\_\_\_\_

*Application for Re-Accreditation in the Nursing Specialty of* \_\_\_\_\_

Signature : \_\_\_\_\_

Date : \_\_\_\_\_

\* Delete as appropriate

Clinical Nurse Specialist Accreditation Panel  
College of Nursing Hong Kong

### Verification of working experience

This is to certify that \_\_\_\_\_ (Name of candidate) has been  
working (Full time/ Part time\*) in \_\_\_\_\_ (Area of specialty) of  
\_\_\_\_\_ (Name of Hospital / Organisation) for  
\_\_\_\_\_ year (s) since \_\_\_\_\_ (Starting date).

Signature : \_\_\_\_\_

Name : \_\_\_\_\_

Designation : \_\_\_\_\_

Contact No. : \_\_\_\_\_

Date : \_\_\_\_\_

**Notes:** \*Please delete as appropriate. If working part-time, please specify the number of  
hours below:

He / She is working \_\_\_\_\_ hours per week / month\*.