

Submission of the Original or Certified True Copy of the Certificate Accompanying Imported Organs after the Transplant of Imported Organs

在移植進口器官後遞交該進口器官附有的證明書的正本或核證真實副本

(to be completed by the registered medical practitioner who transplanted the imported organ(s) into a recipient in Hong Kong)
(由在香港把進口器官移植於受贈人體內的註冊醫生填寫)

Note for completion 填寫須知:

- (1) The duly completed form, together with the original or certified true copy of the Certificate accompanying the imported organ(s) (**the Certificate**), should be submitted to the Human Organ Transplant Board (**the Board**) **within 7 working days** after the transplant. A certified true copy must be certified by the registered medical practitioner who imported the organ to be a true copy of the Certificate.
本表格須連同該進口器官附有的證明書(證明書)的正本或核證真實副本，於器官移植後的**7個工作天內**遞交予人體器官移植委員會(委員會)。核證真實副本必須是經輸入該器官的註冊醫生核證為證明書的真實副本的一份文本。
- (2) Fax copy or photocopy of the Certificate is not acceptable.
證明書的傳真版本或複印本，概不接受。
- (3) Submission of this form and the certified true copy of the Certificate is not required if the original of the Certificate has been supplied to the Board.
如證明書的正本已遞交予委員會，則註冊醫生無須再遞交此表格及證明書的核證真實副本。

Part I 第一部

(Please complete this part if the transplanting registered medical practitioner also imported the organ(s))
(如進行移植的註冊醫生同為輸入該器官的醫生，請填寫此部)

I am the importing practitioner and I transplanted the imported organ(s) as referred to in the Certificate, namely, _____ [description of organ(s)] into a recipient in Hong Kong on _____ [date]. I confirm that a copy of the Certificate has first been supplied to the Board on _____ [date] before the transplant. In accordance with section 7(6) of the Human Organ Transplant Ordinance (Cap. 465), *the original/ a certified true copy of the Certificate is now supplied to the Board.
本人為器官的進口醫生，並已於 _____ [日期] 在香港將證明書內所述的進口的器官，即 _____ [器官的說明]，移植於受贈人體內。本人確證明書的副本已於移植前，即 _____ [日期]，首次提供予委員會。根據香港法例第 465 章《人體器官移植條例》第 7(6)條規定，本人現提供該證明書的*正本/核證真實副本予委員會。

Name of Registered Medical Practitioner 註冊醫生姓名 *HK Identity Card No. 香港身分證號碼/Passport No. (please specify the place of issue) 護照號碼 (請指明發出地點) /Other identity document No. (please specify the type of document and place of issue) 其他身分證明文件號碼 (請指明文件類別及發出地點)

Telephone number 電話號碼

Fax number 傳真號碼

Hospital name/Name and address of Clinic or Institution

醫院名稱/診所或機構的名稱及地址

Date 日期

Signature of Registered Medical Practitioner 註冊醫生簽署

Part II 第二部

(Please complete this part if the transplanting registered medical practitioner did not import the organ(s))

(如進行移植的註冊醫生並非安排輸入該器官的醫生，請填寫此部)

I am the registered medical practitioner who transplanted the imported organ(s) as referred to in the Certificate, namely _____ [description of organ(s)] into a recipient in Hong Kong on _____ [date], but I am not the registered medical practitioner who imported the organ (**importing practitioner**). I confirm that a copy of the Certificate has first been supplied to the Board on _____ [date] before the transplant. In accordance with section 7(6) of the Human Organ Transplant Ordinance (Cap. 465) (**the Ordinance**), *the original/ a certified true copy of the Certificate is now supplied together with this declaration to the Board.

本人是在香港把在證明書內所述的進口的器官，即 _____ [器官的說明]，於 _____ [日期] 移植於受贈人體內的註冊醫生，但本人並非輸入該器官的註冊醫生(進口醫生)。本人確認證明書的副本已於器官移植前，即 _____ [日期]，首次提供予委員會。根據香港法例第 465 章《人體器官移植條例》(條例)第 7(6)條規定，本人現連同本表格一併提供該證明書的*正本/核證真實副本予委員會。

[If a certified true copy of the Certificate is supplied, please also complete the following part] –
[若所提供的是證明書的核證真實副本，請同時填寫下部] –

I hereby declare, in accordance with section 7(8) of the Ordinance, that to the best of my knowledge and belief, the certified true copy of the Certificate was certified by the importing practitioner namely _____ [name of importing practitioner] of that/those organ(s).

本人現謹遵《條例》第 7(8)條聲明，盡本人所知所信，證明書的核證真實副本是經該器官的進口醫生 _____ [進口醫生姓名] 核證的。

Name of Registered Medical Practitioner	註冊醫生姓名	*HK Identity Card No. 香港身分證號碼/Passport No. (please specify the place of issue) 護照號碼 (請指明發出地點) /Other identity document No. (please specify the type of document and place of issue)其他身分證明文件號碼 (請指明文件類別及發出地點)
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Telephone number 電話號碼

Fax number 傳真號碼

Hospital name/Name and address of Clinic or Institution

醫院名稱/診所或機構的名稱及地址

Date 日期

Signature of Registered Medical Practitioner 註冊醫生簽署

* Delete whichever is inapplicable 刪去不適用者

Please tick the box which is applicable and fill in the information as required 請在適用的空格內填上“√”號及填寫所需的資料