

**Hospital Authority (HA)  
Hong Kong Children's Hospital  
醫院管理局  
香港兒童醫院  
Application Form of Fee  
Waiver for Mortuary  
Service  
(Special Transitional Arrangement)**

Please submit the completed Application Form **in person** or **by mail** to the hospital's Death Documentation Office  
請將填妥的申請表親自或以郵寄方式遞交至本院的死亡文件辦事處  
Address 地址: Death Documentation Office, 5/F, Tower A, Hong Kong Children's Hospital, 1 Shing Cheong Road, Kowloon Bay, Kowloon, Hong Kong  
香港九龍九龍灣承昌道一號香港兒童醫院A座五樓死亡證件辦事處  
Telephone 電話: 3513 6258

**殮房服務收費豁免申請表（特別過渡安排）**

**Application Notice on the Special Transitional Arrangement 特別過渡安排申請須知：**

- (a) The charges for mortuary service at HA are effective from 1 January 2026.  
醫院管理局殮房服務收費已於 2026 年 1 月 1 日起實施。
- (b) On compassionate ground, for the deceased whose bodies have been stored in HA mortuary on or before 31 December 2025, the next-of-kin or representative of the deceased can apply special transitional arrangement:
- Waiver of the mortuary charge from 1 to 28 January 2026; and
  - Adjustment of the mortuary charge to \$200 per day from 29 January to 4 February 2026 ; \$550 per day thereafter.
- 基於恩恤考量，如遺體於 2025 年 12 月 31 日或之前已存入醫管局殮房，親屬或先人代表可申請特別過渡安排：
- 減免 2026 年 1 月 1 日至 28 日的殮房收費；及
  - 2026 年 1 月 29 日至 2 月 4 日的殮房收費調整至每日 200 元；其後為每日 550 元。

**Deceased Patient Particulars 已故病人資料**

Name (English) : \_\_\_\_\_ 中文姓名 : \_\_\_\_\_

HKID No./ Passport No.\* 香港身份證／護照號碼\* : \_\_\_\_\_

**Signature of Next-of-kin or Representative of the Deceased 親屬或先人代表簽署**

\_\_\_\_\_  
Name of Next-of-kin or  
Representative of the Deceased  
親屬或先人代表姓名

\_\_\_\_\_  
Relationship with Deceased  
親屬或先人代表與死者關  
係

\_\_\_\_\_  
HKID No.  
香港身份證號碼

*I would like to apply for the fee waiver for mortuary charge (Special Transitional Arrangement). 本人欲申請殮房服務收費豁免（特別過渡安排）。*

\_\_\_\_\_  
Signature  
簽署

\_\_\_\_\_  
Date  
日期

**This part to be completed by Death Documentation Office**

The deceased's body stored in hospital mortuary before 1 January 2026

☐ Yes ☐ No

Remarks: \_\_\_\_\_

Staff Name and Signature :

Date :

\_\_\_\_\_

\_\_\_\_\_

**This part to be completed by Finance**

Recommendation :

☐ Hospital Chief Executive for waiver approval [Amount \$\_\_\_\_\_]

☐ Waiver is not supported Reason : \_\_\_\_\_

Remarks: \_\_\_\_\_

Staff Name and Signature :

Date :

\_\_\_\_\_

\_\_\_\_\_