

SENARAI SEMAK

Sila tandakan ✓ jika berkenaan:-

1. Borang **APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE Rcred 1 - (2018)** perlu diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan serta ditandatangani oleh Ketua Jabatan/ Pakar Lawatan Klinikal Anestesiologi. ☐
2. Salinan Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Kejururawatan / Penolong Pegawai Perubatan yang disahkan – (tahun semasa)* ☐
3. Salinan Sijil *Credentialing* yang bakal tamat tempoh. ☐

Nota : **Borang permohonan bagi Memperbaharui Sijil Credentialing mesti dipohon dan dihantar 6 (enam) bulan sebelum tarikh tamat tempoh Sijil Credentialing.*
***Sijil Credentialing tamat tempoh yang melebihi 1 tahun perlu membuat permohonan baru.*

Semua Borang dan Salinan Sijil hendaklah dihantar dalam satu salinan sahaja.

Borang Permohonan Memperbaharui Sijil *Credentialing* boleh dimuat turun dari portal KKM: www.moh.gov.my. – **Credentialing Assistant Medical Officer & Nurses**

Alamat untuk menghantar Borang Permohonan :

1) PENOLONG PEGAWAI PERUBATAN

KETUA PENOLONG PEGAWAI PERUBATAN
CAW. PERKHIDMATAN PENOLONG PEGAWAI PERUBATAN
BAHAGIAN AMALAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA
ARAS 6, BLOK E1, KOMPLEKS E, PRESINT 1
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62590 PUTRAJAYA
Tel : 03 8883 1370
Faks : 03 8883 1490

TANDATANGAN

Di semak oleh :

(Cop Nama Penyelia)

Tel :

APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE

Name of Hospital :

Name of Applicant:

Identity Card No :

Position :

Tel. Number : Office: Mobile:

Email Address :

Area of recredentialing applied for (*tick in the appropriate box*) :

- | | |
|--|--|
| <input type="checkbox"/> Perioperative Care | <input type="checkbox"/> Orthopaedic Services |
| <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Endoscopy Services |
| <input type="checkbox"/> Emergency Medicine & Trauma Services | <input type="checkbox"/> Cardiovascular Perfusion |
| <input type="checkbox"/> Intensive Care Nursing | <input type="checkbox"/> Peri-Anaesthesia Care (P.A.C) |
| <input type="checkbox"/> Dialysis Care: | <input type="checkbox"/> Diagnostic Radiography |
| <input type="checkbox"/> Haemodialysis | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Peritoneal Dialysis | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Anaesthesiology & Intensive Care Services | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Anaesthesia | <input type="checkbox"/> Dental Technology |
| <input type="checkbox"/> Peri-anaesthesia | <input type="checkbox"/> Optometry |
| <input type="checkbox"/> Intensive Care | <input type="checkbox"/> Dietetic |
| <input type="checkbox"/> General Paediatric Nursing | <input type="checkbox"/> Speech Language Therapy |
| <input type="checkbox"/> Neonatal Nursing | <input type="checkbox"/> Audiology |
| <input type="checkbox"/> Pre Hospital Care Services | |

Presently Credentialed from till

Present Credentialing Certificate No.:

Current APC No.:

PLACE OF WORK SINCE OBTAINING CREDENTIALING CERTIFICATE

Please use additional sheets for extra space

Hospital	Place of work	Duration (From – Till)

DECLARATION
<p>I request to renew my credentialing certificate in the above area for a period of 3 years. I hereby declare the information given is correct.</p> <p>Date: Applicant's Signature.....</p>
RECOMMENDATION BY HEAD OF DEPARTMENT/ UNIT
<p>I certify that the above information is correct and this application is:</p> <p><input type="checkbox"/> recommended</p> <p><input type="checkbox"/> not recommended.</p> <p>..... Date :</p> <p>Signature</p> <p>Official stamp :</p>
DECISION OF SPECIALTY SUB-COMMITTEE (SSC)
<p>This application is <input type="checkbox"/> Approved <input type="checkbox"/> Deferred* <input type="checkbox"/> Rejected*</p> <p>*Reasons:</p> <p>.....</p> <p>.....</p> <p>Signature Date</p>
<p>The above decision will be forwarded to the National Credentialing Committee (NCC) meeting for endorsement.</p>