SENARAI SEMAK

Sila tandakan √ jika berkenaan:-

1. Borang ***APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE* – Rcred 1 (2018)** perlu diisi dengan lengkap oleh pemohon dan ditandatangani oleh Ketua Jabatan/ Pakar Lawatan Klinikal ☐

2. Salinan Perakuan Pendaftaran Tahunan *Annual Practicing Certificate* (APC) Kejururawatan (tahun semasa)* ☐

3. Salinan Sijil *Credentialing* yang bakal tamat tempoh. ☐

Nota : *Borang permohonan bagi Memperbaharui Sijil *Credentialing* mesti dipohon dan dihantar enam (6) bulan sebelum tarikh tamat tempoh Sijil *Credentialing*.
**** Sijil *Credentialing* tamat tempoh yang melebihi satu (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 & Nurse***

Alamat untuk menghantar Borang Permohonan :

1) *JURURAWAT*

PENGARAH
BAHAGIAN KEJURURAWATAN
KEMENTERIAN KESIHATAN MALAYSIA
LOBI 3, ARAS 3, BLOK E7, KOMPLEKS E, PRESINT 1
PUSAT PENTADBIRAN KERAJAANPERSEKUTUAN 62590
PUTRAJAYA

Tel : 03 8883 3543/3544/3546
Faks : 03 8890 4149

TANDATANGAN
Di semak oleh :.....
(Cop Nama Penyelia)
No. 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*) :

[ ] Perioperative
[ ] Ophthalmology
[ ] Emergency Medicine & Trauma Services
[ ] Intensive Care Nursing
[ ] Dialysis Care:
  [ ] Haemodialysis
  [ ] Peritoneal Dialysis
[ ] Anaesthesiology & Intensive Care Services
  [ ] Anaesthesia
  [ ] Peri-anaesthesia
  [ ] Intensive Care
[ ] Paediatric Nursing
[ ] Neonatal Nursing
[ ] Pre Hospital Care Services
[ ] Orthopaedic Services
[ ] Endoscopy Services
[ ] Cardiovascular Perfusion
[ ] Peri-Anaesthesia Care (P.A.C)
[ ] Diagnostic Radiography
[ ] Radiation Therapy
[ ] Physiotherapy
[ ] Occupational Therapy
[ ] Dental Technology
[ ] Optometry
[ ] Dietetic
[ ] Speech Language Therapy
[ ] Audiology

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

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.

Date: …… Applicant's Signature.....

RECOMMENDATION BY HEAD OF DEPARTMENT/ UNIT

I certify that the above information is correct and this application is:
[ ] recommended
[ ] not recommended.

…….....……..... Date : ……
Signature

Official stamp :

DECISION OF SPECIALTY SUB-COMMITTEE (SSC)

This application is [ ] Approved [ ] Deferred* [ ] Rejected*

*Reasons: …….

……

……

Signature …… Date ……..

The above decision will be forwarded to the National Credentialing Committee (NCC) meeting for endorsement.