SENARAI SEMAK

Sila tandakan √ jika berkenaan

1. Borang Permohonan *APPLICATION FOR CREDENTIALING* - ***Cred 1- (2018)*** diisi dengan lengkap oleh pemohon dan ditandatangani oleh Ketua Jabatan / Pakar Lawatan Klinikal ☐
2. Salinan Perakuan Pendaftaran Tahunan *Annual Practicing Certificate* (APC) Kejururawatan yang disahkan (tahun semasa)* ☐
3. Salinan Sijil Perakuan Jururawat ☐
4. Salinan Sijil Yang Disahkan:-

   4.1 Pos Basik Perawatan Paliatif ☐
5. Gambar beruniform berukuran passport. ☐
6. Ringkasan buku log disahkan oleh Ketua Jabatan / Pakar Lawatan Klinikal ☐

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

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

Alamat untuk menghantar Borang Permohonan :

1) *JURURAWAT*

PENGARAH
BAHAGIAN KEJURURAWATAN
KEMENTERIAN KESIHATAN MALAYSIA
LOBI 3, ARAS 3, BLOK E7, KOMPLEKS E, PERSINT 1
PUSAT PENTADBIRAN KERAJAANPERSEKUTUAN
62590 PUTRAJAYA
(u/p: Unit *Credentialing & Privileging*)

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

TANDATANGAN

Di semak oleh :.....

(Cop Nama Penyelia)

APPLICATION FOR CREDENTIALING

HOSPITAL: _____

DATE OF APPLICATION: _____

1. PERSONAL DETAILS

Name: …….

Identification Card Number: ……..……

Area/ Discipline/ Specialty: ……

Photo

Staff position : Nurse ☐

Assistant Medical Officer ☐

AHP ☐ Please state

……..……..

Telephone Number: Office : …….. Mobile: ……

Email Address : ……

N.B Please (/) in the appropriate box

Date of first appointment : ……,

Duration of service: ……. years

2. PROFESSIONAL QUALIFICATIONS		
Diploma / Degree / Masters/ etc.	University/ College	Year of qualification

(Please attach certified copies of degree /diploma /certificate with the form)

3. POST BASIC TRAINING / RELATED COURSES			
Type of Training	Institution	Duration (month)	Year

(Please attach certified copies of certificates obtained, Please use attachment sheet if space inadequate)

4. WORKING EXPERIENCE (start from the current place of work)			
Discipline	Place	Period (from – till)	Duration

(Use attachment sheet if space inadequate)

5. PROFESSIONAL REGISTRATION
Registered with : …… (example: Lembaga Jururawat Malaysia, Lembaga Pembantu Perubatan Malaysia, Majlis Optik Malaysia) Date of Full Registration with respective professional Board/Council : …….. Current Annual Practicing Certificate No.: …….

(Please attach certified copies of Registration certificate)

6. CREDENTIALING APPLIED

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

6.1 Credentialling applied for : ☐ Core Procedures

☐ Specialised Procedures in

a)……..

b)……..

c)……..

☐ Optional Procedures

a) ……..

b) ……..

c) ……..

7. PLEASE NAME TWO REFEREES

NAME	POSITION	PLACE OF WORK

I hereby declare that all the information given above are true and correct.

Signature of applicant: ……

Date: ……

8. PLEASE COMPLETE THE FOLLOWING ASSESSMENT OF THE APPLICANT'S ETHICAL AND PROFESSIONAL QUALIFICATIONS.
Please (√) at the appropriate box

	Above Average	Average	Below Average	No knowledge
Clinical knowledge				
Clinical skills				
Professional clinical judgment				
Sense of clinical responsibility				
Ethical conduct				
Cooperativeness, ability to work with others				
Documentation/ medical record timeliness & quality				
Teaching skills				
Compliance with hospital rules & regulation				

9. APPLICANT APPRAISAL (to be filled by Supervisor)

9.1 I have known the applicant for ……..…….. (duration)

9.2 I recommend / do not recommend the applicant to be credentialed in the field requested. (delete where applicable)

…… Date : ……..

Signature

Official stamp:

Contact No:

10. **APPLICATION APPROVAL (By Head of Department)**

……..is approved/ not approved for submission to the National Credentialing Committee

…… Date : ……..

Signature

Official stamp:

FOR OFFICIAL USE

SPECIALTY SUB-COMMITTEE (SSC) DECISION

Application Approved ☐

For Reassessment* ☐

Application Rejected* ☐

*Reasons:

……

……

……

Specialty Sub-Committee Chairman …… Date……

Signature

The above decision will be brought to the next NCC meeting for endorsement

SUMMARY OF LOG BOOK FOR PALLIATIVE CARE

NAME:
I/C NO:

NO	PROCEDURES	REQUIRED			DONE			REMARKS
		O	A	P	O	A	P	
1	Genogram	-	-	3				
2	Holistic assessment	-	-	3				
3	Assess ECOG/Karnofsky Performance Scale	-	-	3				
4	Oral care	-	-	3				
5	Abdominal examination	-	-	3				
6	Care of pigtail	-	-	3				
7	Stoma care	-	-	3				
8	Respiratory examination	-	-	3				
9	Care of patient in severe breathlessness	-	-	3				
10	Identify respiratory depression (Opioid induced)	-	-	3				
11	Neurological assessment and examination	-	-	3				
12	Skin assessment and skin care	-	-	3				
13	Per rectum examination	-	-	3				
14	Manual evacuation of rectum	-	-	3				
15	High enema	-	-	3				
16	Wound de-sloughing / debridement	-	-	3				
17	Pain assessment	-	-	3				
18	Opioid calculation and conversion	-	-	3				
19	Administration of immediate release (IR) opioid	-	-	3				
20	Administration of slow release (SR) opioid	-	-	3				
21	Administration of sub cutaneous injection	-	-	3				
22	Preparation and administration of opioid infusion	-	-	3				
23	Preparation and administration of non-opioid drug infusion	-	-	3				
24	Administration of transdermal fentanyl	-	-	3				
25	Assess sedation score	-	-	3				
26	Administration of breakthrough pain medication	-	-	3				
27	Perform subcutaneous cannula / line insertion	-	-	3				
28	Perform dying patient assessment	-	-	3				
29	Administration of crisis medications	-	-	3				
30	Preparation of disposable infusion pump	-	-	3				
31	Checking and calibrating syringe driver	-	-	3				
32	Family conference	-	-	3				
33	Psychological assessment using proper tools (HADS, DASS, DT)	-	-	3				
34	Preparation for terminal discharge	-	-	3				
35	Preparation for hospice referral	-	-	3				

COMMENTS BY ASSESSOR / HEAD OF DEPARTMENT:

_____

_____

Signature of Assessor

……

(Name / Stamp)

Date :

Verified by HOD

……

(Name / Stamp)

Date: