SENARAI SEMAK

Sila tandakan √ jika berkenaan

1. Borang permohonan baru ***APPLICATION FOR CREDENTIALING*** **Cred 1- (2018)** diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan daripada Penyelia Penolong Pegawai Perubatan serta disahkan oleh Pakar Bedah/ Pakar Perubatan Keluarga (FMS). ☐

2. Salinan Diploma/ Ijazah Pembantu Perubatan yang diiktiraf oleh Lembaga Pembantu Perubatan Malaysia. ☐

3. Salinan Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Penolong Pegawai Perubatan - (tahun semasa).* ☐

4.1 Salinan Sijil Lulus T.O.T Berkhatan Penolong Pegawai Perubatan KKM ☐

ATAU

4.2 Salinan Sijil Lulus Berkhatan anjuran Pusat Tanggungjawab (PTJ) yang **disokong** oleh Penyelia Penolong Pegawai Perubatan dan **disahkan** oleh Pakar Bedah/ Pakar Perubatan Keluarga (FMS). ☐

5. Gambar ukuran passport dengan beruniform lengkap. ☐

6. Ringkasan buku log disahkan oleh Pakar Bedah/ Pakar Perubatan Keluarga (FMS). -*berkuatkuasa mulai 1.1.2022. ☐

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

Borang Permohonan Baru *Credentialing* boleh dimuat turun dari portal KKM: www.moh.gov.my.– *Credentialing Assistant Medical Officers & 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, PERSINT 1
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62590 PUTRAJAYA

Tel : 03 8883 1370/ 1374
Faks : 03 8883 1490

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

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 (to be filled by Supervisor)

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.