

**SENARAI SEMAK PERMOHONAN PEMBAHARUAN SIJIL (RE-CREDENTIALING)
NEONATAL NURSING**

Sila tandakan ✓ jika berkenaan dalam kotak yang disediakan:

Bil.	Maklumat	Tandakan ✓
1.	Borang permohonan baru APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE Rcred 1- (2018) diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan serta ditandatangani oleh:- a. Hospital berpakar : Ketua Jabatan Pediatrik b. Hospital tanpa pakar : Pakar Lawatan Klinikal	<input type="checkbox"/>
2.	Salinan Sijil Perlu Disahkan Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	2.1 Perakuan Pendaftaran Tahunan <i>Annual Practising Certificate (APC)</i> Jururawat - (APC tahun terkini).*	<input type="checkbox"/>
	2.2 Sijil <i>Credentialing</i> yang bakal tamat tempoh.	<input type="checkbox"/>

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

**Sijil Credentialing tamat tempoh melebihi 1 tahun perlu membuat permohonan baru.

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, PRESINT 1
PUSAT PENTADBIRAN KERAJAAN PUTRAJAYA
625920 PUTRAJAYA

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

Disemak oleh :
(Cop Nama Penyelia)

No Telefon Penyelia :

APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE

Name of Hospital :
 Name of Applicant :
 Identity Card No :
 Position :
 Tel. Number : Office :
 : Mobile :
 Email Address :

Area of re-credentialing applied for (*tick in the appropriate box*) :

- | | |
|--|--|
| <input type="checkbox"/> Perioperative | <input type="checkbox"/> Orthopedic Services |
| <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Endoscopy Services |
| <input type="checkbox"/> Emergency Medicine & Trauma Services | <input type="checkbox"/> Peri-Anaesthesia Care (P.A.C) |
| <input type="checkbox"/> Intensive Care Nursing | <input type="checkbox"/> Cardiovascular Perfusion |
| <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"/> Occupational Therapy |
| <input type="checkbox"/> Anaesthesiology & Intensive Care Services | <input type="checkbox"/> Physiotherapy |
| <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 Pediatrics 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

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 PAEDIATRIC / VISITING CLINICAL PAEDIATRIC SPECIALIST

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.