

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

Sila tandakan $\sqrt{\quad}$ jika berkenaan dalam kotak yang disediakan:

Bil.	Maklumat	Tandakan $\sqrt{\quad}$
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 <i>Intensive Care</i> b. Hospital tanpa pakar : Pakar Lawatan Klinikal <i>Intensive Care</i>	<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 :

Rcred 1 - (2018)

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