SENARAI SEMAK PERMOHONAN BAHARU (*CREDENTIALING*) ORTOPEDIK BAGI PENOLONG PEGAWAI PERUBATAN DAN JURURAWAT

Sila tandakan √ jika berkenaan dalam kotak yang disediakan:

Bil.	Maklumat	Tandakan √
1.	Borang permohonan baru ***APPLICATION FOR CREDENTIALING*** **Cred 1- (2018)** diisi dengan lengkap oleh pemohon dengan mendapatkan: i. **Sokongan & ditandatangan** oleh:- Penyelia Jabatan Ortopedik yang telah di *credential*. ii. **Kelulusan & ditandatangan** oleh:- a. **Hospital berpakar**: Ketua Jabatan Ortopedik. b. **Hospital tanpa pakar**: Pakar Lawatan Klinikal Ortopedik.	☐
2.	Ringkasan buku log yang ditandatangan oleh *assessor* (penyelia yang telah di *credential*) dan disahkan oleh:- a. **Hospital berpakar**: Ketua Jabatan Ortopedik. b. **Hospital tanpa pakar**: Pakar Lawatan Klinikal Ortopedik.	☐
3.	Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	3.1 Perakuan Pendaftaran Sebagai Pembantu Perubatan/ Jururawat	☐
	3.2 Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Jururawat / Penolong Pegawai Perubatan - (APC tahun terkini).*	☐
	3.3 Pos Basik/ Diploma Lanjutan Perawatan Ortopedik – *(Jika berkaitan)*	☐
4.	Gambar beruniform berukuran passport.	☐

Borang Permohonan Baru *Credentialing* boleh dimuat turun dari portal KKM: www.moh.gov.my.– *Credentialing Assistant Medical Officer & 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
Faks : 03 8883 1490

2) *JURURAWAT*

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

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

Disemak oleh: ……..

No. Tel : ……

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

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 Orthopaedic 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 Orthopaedic/ Visiting Orthopaedic Specialist)

……..…….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 STAFF'S PROGRESS CLINICAL PRACTICE RECORDS FOR ORTHOPAEDICS SERVICES

Name :……

No. I/C :……..

NO	PROCEDURES	Required			Done			Remarks
		O	A	P	O	A	P	
1	Preparation and application of Thomas Splint	1	1	1				1
2	Preparation and application of Bohler Braun Frame	1	1	1				1
3	Application and care of patient on skin traction	2	2	2				1
4	Application and care of patient on skeletal traction	2	2	2				1
5	Application and care of patient on Fixed traction	2	2	2				1
6	Care of patient with Plaster of Paris	2	2	2				2
7	Application and care of Halter Traction *	1	1	1				2
8	Assist application and care of patient with Halovest *	1	1	1				3
9	Assessment of neurovascular status - With traction - With cast - Post – operative	 2 2 2	 2 2 2	 2 2 2				1
10	Pre and post op care of patient : Amputation	2	2	2				2
11	Pre and post op care of patient : Trauma	2	2	2				2
12	Pre and post op care of patient : Non trauma	2	2	2				2
13	Application of cryo cuff	1	1	1				1
14	Application of CPM*	1	1	1				1
15	Immediate and management of spinal injury - Log turning - Skin care - Bowel training - Bladder training	 2 2 2 2	 2 2 2 2	 2 2 2 2				2
16	Health education and exercise : - Range of motion upper and lower limb - Static Quadriceps - Ankle foot pump exercise - Deep breathing exercise	 1 1 1 1	 1 1 1 1	 1 1 1 1				1

NO	PROCEDURES	Required			Done			Remarks
		O	A	P	O	A	P	
17	Ambulating patient - With crutches - With walking frame - Wheelchair	 2 2 2	 2 2 2	 2 2 2				2
18	Care of patient with cast/ slab	1	1	1				1
19	Interpretation of plain x ray - Upper limb - Lower Limb - Spine	 2 2 2	 2 2 2	 2 2 2				2
20	Application of arm sling	1	1	1				1
21	Application of Stump bandage	1	1	1				1
22	Application of limb bandage	2	2	2				1
23	Principle and Care of orthosis - Knee brace - Juwette Brace - SOMI brace	 1 1 1	 1 1 1	 1 1 1				2
24	Application shoulder strapping	2	2	1				1
25	Application of Volar Slab	2	2	5				1
26	Application of Dorsal Slab	2	2	1				1
27	Application of Above Elbow Backslab	2	2	5				1
28	Application of Above Elbow Cast	2	2	5				1
29	Application of Below Elbow cast	2	2	5				1
30	Application of Below elbow backslab	2	2	5				1
31	Application of Colle's cast	2	2	5				2
32	Application of Bennet Cast	2	2	1				2
33	Application of Ulnar Gutter	2	2	5				2
34	Application of Thumb Spica	2	2	5				2
35	Application of Scaphoid cast	2	2	1				2
36	Application of Hanging Cast	2	2	1				2
37	Application of 'U' Slab	2	2	5				2
38	Application of Below knee back slab	2	2	5				1
39	Application of Above knee backslab	2	2	5				1
40	Application of Above knee Cast	2	2	5				2

NO	PROCUDERS	Required			Done			Remarks (Category of procedure)
		O	A	P	O	A	P	
41	Application of Below knee Cast	2	2	5				2
42	Application of Cylinder back slab	2	2	1				1
43	Application of Cylinder Cast	2	2	1				2
44	Application of Boot Cast	2	2	1				2
45	Application of Patellar Tendon Bearing cast	2	2	5				2
46	Application of body Cast*	1	1	1				2
47	Application of Minerva Jacket*	1	1	1				2
48	Application of hip spica	2	2	1				2
49	Application of serial casting for CTEV / Ponseti Cast	2	2	5				2
50	Wedging of Cast	2	2	2				2
51	Removal of Halovest	1	1	1				2
52	Removal of external fixator	2	2	5				2
53	Removal of Cast	2	2	5				1
54	Perform Closed Manual Reduction (CMR) - AMO	2	2	5				2
	Perform Closed Manual Reduction (CMR) - Nurses	2	2	0				2
	TOTAL PROCEDURES	**119**	**119**	**124**				

Notes : O (Observe):1 A (Assist):1 P (Perform):1
* - The procedure may be uncommon (rare) procedure in the unit.

Category of procedure: 1 : Basic procedure
2 : Complex procedure

COMMENTS BY ASSESSOR / HEAD OF DEPARTMENT :

Signature of Assessor :

……

(Name / Stamp)

Date :

Verified by Head Of Department Orthopaedic/
Visiting Orthopaedic Specialist:

…….

(Name / Stamp)

Date: