SENARAI SEMAK PERMOHONAN BAHARU (*CREDENTIALING*)
GENERAL PAEDIATRIC NURSING

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 dan mesti mendapatkan sokongan serta ditandatangan oleh:- **a. Hospital berpakar**: Ketua Jabatan Pediatrik **b. Hospital tanpa pakar**: Pakar Lawatan Klinikal Pediatrik	☐
2.	Ringkasan buku log yang ditandatangan oleh *assessor* dan disahkan oleh:- a. **Hospital berpakar**: Ketua Jabatan Pediatrik b. **Hospital tanpa pakar**: Pakar Lawatan Klinikal Pediatrik *(bagi yang tiada pos basik/ diploma lanjutan berkaitan)**	☐
3.	Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	3.1 Perakuan Pendaftaran Sebagai Jururawat	☐
	3.2 Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Jururawat - (APC tahun terkini).*	☐
	3.3 Sijil Pos Basik Perawatan Pediatrik (jika ada)	☐
	3.4 Sijil *Basic Life Support (BLS) / Paediatric Life Support (PLS) / Paediatric Advance Life Support (PALS)*	☐
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 :

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

Di semak oleh :.....
(Cop Nama Penyelia)
No Telefon 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 :-
[ ] Anaesthesia
[ ] Peri-anaesthesia
[ ] Intensive Care
[ ] General Paediatric Nursing
[ ] Neonatal Nursing
[ ] Orthopaedic Services
[ ] Endoscopy Services
[ ] Peri-Anaesthesia Care (P.A.C)
[ ] **General Paediatric Nursing**
[ ] Cardiovascular Perfusion
[ ] Pre Hospital Care Services
[ ] Physiotherapy
[ ] Occupational Therapy
[ ] Diagnostic Radiography
[ ] Radiation Therapy
[ ] Dental Technology
[ ] Speech Language Therapy
[ ] Dietetic
[ ] Audiology

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 Paediatric Department)

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 Paediatric Department / Visiting Clinical 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 NURSES PROGRESS CLINICAL PRACTICE RECORD FOR PEDIATRIC (CORE PROCEDURES)

NAME:
I/C NO:

No.	Procedures	Required	Done	Remarks
1.	Assess patient on admission	5		
2.	Assess level of consciousness	5		
3.	Venepunture	10		
4.	Peripheral venous cannulation	10		
5.	Heel/ finger prick for capillary blood sugar	10		
6.	Insertion of naso/orogastric tube	10		
7.	Enteral tube feeding	5		
8.	Collection of urine culture	5		
9.	Peak Flow meter measurement	5		
10.	Administration of metered dose inhaler	5		
11.	Nebulisation	10		
12.	Assist lumber puncture	2		
13.	Blood transfusion	3		
14.	Administration of oral medication	3		
15.	Administration of medication by rectal route	3		
16.	Monitoring of patient under sedation	3		
17.	Suctioning – oro/nasopharyngeal	5		
18.	Bag valve mask ventilation	3		
19.	Use of cardiorespiratory monitor and alarm limit setting	3		
20.	Care of patient with chest tube placement	2		
21.	Intra/ Interhospital transfer of patient	3		

COMMENTS :

Signature of Assessor

……
(Name / Stamp)
Date :

Verified by Head of Pediatric Department / Visiting Clinical Specialist

……
(Name / Stamp)
Date:

SUMMARY OF NURSES PROGRESS CLINICAL PRACTICE RECORD FOR GENERAL PAEDIATRIC NURSING (OPTIONAL PROCEDURES)

NAME:

I/C NO:

No.	Procedures	Required	Done	Remarks
1.	Assist in central line placement	10		
2.	Care of central venous line	10		
3.	Care of chemo port	10		
4.	Setting up total parenteral nutrition	5		
5.	Assist intubation	5		
6.	Suctioning – endotracheal	5		
7.	Care of patient with tracheostomy	5		
8.	Blood sampling from arterial line	5		
9.	Care of patient on non –invasive ventilation	5		
10.	Stoma care	5		
11.	Phototherapy	5		
12.	Checking photolight irradiance	5		
13.	Assist bone marrow aspiration	3		
14.	Assist chest tube placement	3		
15.	Assist bladder catheterization	3		
16.	Care of patient on peritoneal dialysis	3		
17.	Wet wrap	3		
18.	Basic ECG	5		

COMMENTS :

_____

_____

_____

Signature of Assessor

Verified by Head of Paediatric Department/
Visiting Clinical Specialist

…… ……

(Name / Stamp) (Name / Stamp)

Date : Date: