

**SENARAI SEMAK PERMOHONAN BAHARU (*CREDENTIALING*)
CARDIOLOGY BAGI PENOLONG PEGAWAI PERUBATAN**

Sila tandakan jika berkenaan dalam kotak yang disediakan:

Bil.	Maklumat	Tandakan <input checked="" type="checkbox"/>
1.	Borang permohonan baru APPLICATION FOR CREDENTIALING Cred 1- (2018) diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan serta ditandatangani oleh Ketua Jabatan/ Pakar Kardiologi.	<input type="checkbox"/>
2.	Ringkasan buku log yang ditandatangani oleh assessor dan disahkan oleh Ketua Jabatan / Pakar Kardiologi.	<input type="checkbox"/>
3.	Salinan Sijil Perlu Disahkan Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	3.1 Perakuan Pendaftaran Sebagai Pembantu Perubatan	<input type="checkbox"/>
	3.2 Perakuan Pembaharuan Tahunan Pembantu Perubatan <i>Annual Renewal Certificate</i> (ARC) - (ARC tahun terkini).*	<input type="checkbox"/>
	3.3 Diploma Lanjutan Perawatan Kesihatan Kardiovaskular (Teknologi)/ Sijil Pos Basik Coronary Care.	<input type="checkbox"/>
4.	Gambar beruniform berukuran passport.	<input type="checkbox"/>

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

Alamat untuk menghantar Borang Permohonan :

KETUA PENOLONG PEGAWAI PERUBATAN
CAW. PERKHIDMATAN PENOLONG PEGAWAI
PERUBATANBAHAGIAN AMALAN PERUBATAN
KEMENTERIAN KESIHATAN
MALAYSIA ARAS 6, BLOK E1,
KOMPLEKS E, PERSINT 1
PUSAT PENTADBIRAN KERAJAAN
PERSEKUTUAN62590 PUTRAJAYA
Tel : 03 8883 1370/ 1374
Faks : 03 8883 1490

Disemak oleh:

.....

No. Tel :

.....

APPLICATION FOR CREDENTIALING

HOSPITAL: _____

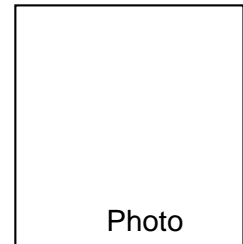
DATE OF APPLICATION: _____

1. PERSONAL DETAILS

Name:

Identification Card Number:

Area/ Discipline/ Specialty:



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

<ul style="list-style-type: none"> <input type="checkbox"/> Intensive Care Nursing <input type="checkbox"/> Peri-Operative Care <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Emergency Medicine & Trauma Services <input type="checkbox"/> Dialysis Care <input type="checkbox"/> Haemodialysis <ul style="list-style-type: none"> <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Anaesthesiology & Intensive Care Services <ul style="list-style-type: none"> <input type="checkbox"/> i. Anaesthesia <input type="checkbox"/> ii. Peri-anaesthesia <input type="checkbox"/> iii. Intensive Care <input type="checkbox"/> General Paediatric Nursing <input type="checkbox"/> Neonatal Nursing <input type="checkbox"/> Orthopaedic Services <input type="checkbox"/> Endoscopy Services <input type="checkbox"/> Peri-Anaesthesia Care (P.A.C) 	<ul style="list-style-type: none"> <input type="checkbox"/> Cardiovascular Perfusion <input type="checkbox"/> Pre Hospital Care Services <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Diagnostic Radiography <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Dental Technology <input type="checkbox"/> Speech Language Therapy <input type="checkbox"/> Dietetic <input type="checkbox"/> Audiology <input type="checkbox"/> Optometry <input type="checkbox"/> Cardiology: Non-Invasive Cardiology (NICL) <ul style="list-style-type: none"> i. <input type="checkbox"/> Transthoracic Echocardiography (TTE) ii. <input type="checkbox"/> Exercise Stress Test iii. <input type="checkbox"/> Holter <input type="checkbox"/> Cardiology: Invasive Cardiology (ICL) <input type="checkbox"/> Cardiology: Cardiac Rhythm Management & Electrophysiology
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6.1 Credentialling applied for : Core Procedures
 Specialised Procedures in Optional Procedures

a).....	a)
b).....	b)
c).....	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)

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
Signature

Date.....

The above decision will be brought to the next NCC meeting for endorsement.

**PROGRESS REPORT
CLINICAL PRACTICE RECORD**

Name :

No. I/C :

Month :

*Note: This summary clinical practice record has to be prepared at the end of each month.

**POLICY AND PROCEDURES ON TRAINING,
CREDENTIALING AND PRIVILEGING
OF ASSISTANT MEDICAL OFFICER IN CARDIOLOGY KKM**

This well being developed logbook divided into three section A, B & C:

- Section A: Non-Invasive Cardiac Laboratory procedures
- Section B: Invasive Cardiac Laboratory Procedures
- Section C: Cardiac Rhythm Management & Electrophysiology Study

All Practical / Hands-on training must be document in this logbook and Local Supervisor will make an evaluation at the end of each procedure. Minimum requirement for each procedure state as below:

SECTION A: Non-Invasive Cardiac Laboratory (NICL)

PROCEDURES	Required			Done		
	O	A	P	O	A	P
Transthoracic Echocardiogram (TTE)	50	50	100			
Treadmill Exercise Stress Test (EST)	25	25	50			
24 Hours Holter Monitoring	25	25	50			
Stress Echocardiogram (Pharmacological/ Exercise)	5	5	10			

Comments By Head Of Department/Cardiologist:

Signature of Assessor :

Verified by Head Of
Department/ Cardiologist

.....

.....

Name / Stamp)

(Name / Stamp)

Date :

Date :

SECTION B : Invasive Cath. Laboratory (ICL)

- This section including of Haemodynamic monitoring & assisting cardiologist in related procedures

PROCEDURES	Required			Done		
	O	A	P	O	A	P
Haemodynamic Monitoring (Coronary Angiogram)	25	25	100			
Haemodynamic Monitoring (Percutaneous Coronary Intervention)	25	25	100			
Haemodynamic Monitoring (Right Heart Catheterization)	5	5	10			
Intra-Aortic Balloon Pump (IABP)	5	5	10			
Intravascular Ultrasound (IVUS)	5	5	10			
Fractional Flow Reverse (FFR/IFR)	5	5	10			

Comments By Head Of Department/Cardiologist:

Signature of Assessor :

Verified by Head Of
Department/ Cardiologist

.....

.....

(Name / Stamp)

(Name / Stamp)

Date :

Date:

SECTION C: Cardiac Rhythm Management & Electrophysiology Study

PROCEDURES	Required			Done		
	O	A	P	O	A	P
Cardiac Rhythm Management/ Cardiac Pacing	25	25	50			
Conducting the follow-up clinic for interrogation, programming and reprogramming of the implantable devices	25	25	50			
Electrophysiology Study (EPS)	5	5	10			
Radiofrequency Ablation (RFA)	5	5	10			
Cryo Ablation	5	5	10			

Comments By Head Of Department/ Cardiologist:

Signature of Assessor :

Verified by Head Of
Department/ Cardiologist

.....

.....

Name / Stamp)

(Name / Stamp)

Date :

Date: