SENARAI SEMAK PERMOHONAN BAHARU PENGIKTIRAFAN CREDENTIALING BAGI PROFESION SAINS KESIHATAN BERSEKUTU

Sila tandakan √ jika berkenaan, dalam kotak yang disediakan:

Bil	Maklumat	Senarai Semak
1.	Borang permohonan baru ***Application For Credentialing* Cred 1- (2018)** hendaklah diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan serta ditandatangani oleh Ketua Unit / Ketua Jabatan	☐
2.	Salinan Sijil Kelayakan (Sijil / Diploma / Ijazah) dalam bidang yang diiktiraf (disahkan).	☐
3.	Salinan Sijil Perakuan Pendaftaran (contohnya Malaysian Allied Health Professions Council) yang disahkan - (Jika berkaitan).	☐
4.	Salinan Sijil Amalan (PC) yang disahkan - (Jika berkaitan).	☐
5.	Salinan Sijil Pos Basik/ Advance Diploma dalam bidang berkaitan dan lain-lain sijil / dokumen sokongan(seminar, kursus, bengkel) yang dihadiri (disahkan).	☐
6.	Gambar pemohon memakai *uniform / overall* berukuran passport.	☐
7.	Ringkasan buku log *(summary log book)* yang disahkan	☐

Alamat untuk menghantar Borang Permohonan:

Pengarah
Bahagian Sains Kesihatan Bersekutu (KKM)
Aras 2, Blok A, Bangunan Utama Chancery Place
Jalan Diplomatik 2, Presint Diplomatik
62050 Putrajaya,
Wilayah Persekutuan Putrajaya.
(Unit Kompetensi & Credentialing)

Tel : 03 - 88901011
Faks : 03 - 88901060

Disemak oleh:

TANDATANGAN

....
(Cop Nama Penyelia)

Tel:
Tarikh:

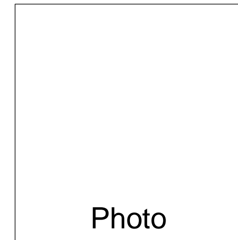
APPLICATION FOR CREDENTIALING

HOSPITAL: ________________________________

DATE OF APPLICATION: ____________________

1. PERSONAL DETAILS

Name: ………………………………………………….………………



Photo

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

- ☐ 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 / ☐ Advanced 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: ………………………

Appraisal of Applicant By Head Of Unit / Department

Name Of Applicant : ______________________________

Profesion/Grade : ______________________________

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 ………………………… Date……………………
Signature

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