## 2. Borang Pembaharuan AMOTeX

**SENARAI SEMAK**

Sila tandakan (√) pada yang berkenaan

1. Borang ***APPLICATION FOR RENEWAL AMOTeX FORM*** yang lengkap. ☐

2. Salinan **Perakuan Pembaharuan Tahunan (PPT)** Penolong Pegawai Perubatan yang disahkan (tahun semasa) ☐

3. Salinan **Sijil *AMOTeX*** yang akan tamat tempoh. ☐

***Nota : Borang permohonan bagi memperbaharui pendaftaran AMOTeX hendaklah dihantar enam (6) bulan sebelum tarikh tamat tempoh Sijil AMOTeX.***

Semua Borang dan Salinan Sijil hendaklah dihantar dalam satu salinan sahaja.

**Alamat Penghantaran Borang Permohonan :**

KETUA PENOLONG PEGAWAI PERUBATAN
CAWANGAN PERKHIDMATAN PENOLONG PEGAWAI PERUBATAN
BAHAGIAN AMALAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA
ARAS 6, BLOK E1, KOMPLEKS E,
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62590 PUTRAJAYA
WILAYAH PERSEKUTUAN PUTRAJAYA

Tel : 03 8883 1370

**Di semak oleh**: .....

(Tandatangan & Cop Ketua Penyelia Hospital/ PKD/ PKK/ PKB)

PKD : Pejabat Kesihatan Daerah

PKK : Pejabat Kesihatan Kawasan

PKB : Pejabat Kesihatan Bahagian

**RENEWAL AMOTeX APPLICATION FORM**

**HOSPITAL / DISTRICT HEALTH OFFICE (PKD/PKK/PKB) :…….....**

Name of Applicant : ……..……

Identity Card No : ……..……..……

Tel. Number : Office : .....

Mobile : .....

Email Address : .....

Area of AMOTeX applied for (*tick in the appropriate box*) :

| | | | |
|---|---|---|---|
| ☐ | Cardiology | ☐ | Neurosurgery |
| ☐ | Cardiovascular Perfusion | ☐ | Obstetrics & Gynecology |
| ☐ | Cardiothoracic Surgery | ☐ | Oncology |
| ☐ | Emergency Medicine & Trauma Services | ☐ | Otorhinolaryngology |
| ☐ | Nephrology | ☐ | Ophthalmology |
| ☐ | Orthopaedic | ☐ | Plastic & Reconstructive Surgery |
| ☐ | Neurophysiology | ☐ | Sports Medicine |
| ☐ | Diabetes | ☐ | Psychiatry & Mental Health |
| ☐ | HIV/AIDS Counseling | ☐ | Radiotherapy & Oncology |
| ☐ | Wound Care Management | ☐ | Respiratory |
| ☐ | Anesthesiology & Intensive Care | ☐ | Urology |
| ☐ | Endoscopy | ☐ | Adolescent Health Programs |
| ☐ | Forensic Medicine | ☐ | Gerontology |
| ☐ | Nuclear Medicine | ☐ | Epidemiology |
| ☐ | Hand & Microsurgery | ☐ | Men's Health Programs |
| ☐ | Infection Control | ☐ | Primary Health Care |
| ☐ | Intensive Care | ☐ | TB/Leprosy |

Presently application for AMOTeX approved from ……..... till .....……

Present AMOTeX Certificate No. : …….....

Current *ARC* No. : …….....

**PLACE OF WORK SINCE OBTAINING AMOTeX CERTIFICATE**

| Hospital / PKD | Area / Disipline / Specialty | Duration (From – Till) |
|---|---|---|
| | | |
| | | |
| | | |

*Please use additional sheets for extra space*

**DECLARATION**

I request to renew my AMOTeX certificate in the above area for a period of 3 years. I hereby declare the information given is correct.

Applicant's Signature : ..... Date : ……

**RECOMMENDATION BY HEAD OF DEPARTMENT (CLINICAL / FMS / PHMS)**

I certify that the above information is correct and this application is:

[ ] recommended [ ] not recommended.

……..……..... Date : ……..... Signature

Official stamp :

**DECISION BY AMOTeX ASSESSMENT COMMITTEE**

This application is [ ] Approved [ ] Deferred* [ ] Rejected*

*Reasons: …….

……

Signature …… Date ……..

The above decision will be brought to the next Medical Assistant Board (MAB) meeting for endorsement