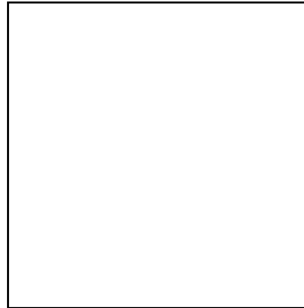
AMP-BOR-01(A)

APPLICATION FOR LETTER OF CREDENTIALING AND PRIVILEGING (CHAPTER 1)

1. PERSONAL DETAILS



Full Name : ____

NRIC / Passport No. : ____

Malaysian Medical Council Reg. No. : ____

Current Annual Practicing Certificate No. /Year : ____

Clinic/Hospital Name : ____

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Home Address : ____

____

Telephone No. Office : ________________ Residence: ________________ Mobile: ______________

Fax No. : ____

Email Address : ____

2. PERSONAL QUALIFICATION / TRAINING

2.1 Basic Qualification:

Qualification : ____

University/Awarding body : ____

Date of Qualification : ______________________

2.2 Work Experience

PERIOD	PLACE OF PRACTICE	POSITION

2.3 Post Graduate Qualification: (If applicable)

Qualification : ____

University/Awarding body : ____

Date of qualification : ____

Years of aesthetic medical practice experience (part time/full time);_________________________________

2.4 Information on Professional Indemnity

Name of insurance provider : ____

Type of insurance : ____

Period of coverage : ____

Policy number : ____

***Note*: Upon approval of the Letter of Credentialing & Privileging, medical practitioners performing aesthetic medical practice should have appropriate professional indemnity.**

3. DECLARATION TO PERFORM AESTHETIC MEDICAL PROCEDURES

Please attach with this application form, a copy of the certificate obtained (overseas or local training), details of training courses, organizers, trainer(s)' name and CV if necessary, details of hands-on experience, duration of course and examinations / tests.

Type of Treatment and Procedure	Tick	No. of Procedures Performed	Name of Trainers/Supervisors	Title of Certificate Obtained
NON-INVASIVE				
Chemical peel (Superficial)				
Microdermabrasion				
Intense pulsed light (IPL)				
MINIMALLY INVASIVE				
Chemical peel (Medium depth)				
Botulinum toxin injection				
Filler injection - excluding silicone and fat				
Superficial sclerotherapy				
Lasers for treating skin pigmentation				
Lasers for skin rejuvenation (including fractional ablative)				
Lasers for hair removal (e.g. long pulsed Nd:YAG, Diode)				
Skin tightening procedures- radiofrequency, ultrasound, infrared up to upper dermis				

Note :
This list may be subject to review.

Additional Information on Training (if any)

Title of Certificate Obtained	Year Obtained	Name of Organiser	Name(s) of Supervisor/ Trainer	Duration	Details of Assessments (theory/viva/hands-on)

4. NAMES OF TWO REFEREES

One referee must be a Malaysian who is a registered medical practitioner practising aesthetic medical practice in Malaysia.

REFEREE 1

Name : ______________________________

IC / Passport No. : ______________________________

Designation : ______________________________

MMC No. : ______________________________

APC No. : ______________________________

LCP No.(if any) : ______________________________

Telephone No. : Office:______________ Residence: ______________Mobile: ______________

Fax No. : ______________________________

Postal Address : ______________________________

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Email Address : ______________________________

Referee's Signature : ______________________________

REFEREE 2

Name : ______________________________

IC / Passport No. : ______________________________

Designation : ______________________________

MMC No. : ______________________________

APC No. : ______________________________

LCP No.(if any) : ______________________________

Telephone No. : Office :______________ Residence: ______________Mobile: ______________

Fax No. : ______________________________

Postal Address : ______________________________

____

Email Address : ______________________________

Referee's Signature : ______________________________

5. DECLARATION

I declare that the information provided in this application form is true and herein remains unchanged to-date. To the best of my knowledge and belief, I have not withheld any material fact. I understand that my practice may be audited. I also note that I may be required to submit additional details for further assessment / review.

_____________________________________ ________________

Name of Medical Practitioner Date

____

Signature

Please submit your application form and supporting documents to:

JOINT SECRETARIAT OF MSAM/SAAARMM
C/O NO. 12, LORONG MAAROF, BANGSAR
59000 KUALA LUMPUR.

Email : jtcommchapt1@gmail.com
Tel : 03-22831212
Fax : 03-2283001

* a processing fee is applicable (kindly refer to the above secretariat)

6. FOR OFFICE USE ONLY
(Joint Secretariat of MSAM/SAAARMM)

6.1 Evidence of adequate training

Please tick the appropriate box Yes ☐ No ☐

6.2 Recommendation for procedures requested

List of procedures	Recommendation		Remarks
	Yes	No	

6.3 Comments/suggestions:

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____

Co-Chairman of Joint
Secretariat of MSAM/SAAARMM
( )

____

Date

____

Co-Chairman of Joint
Secretariat of MSAM/SAAARMM
( )

____

Date

7. FOR OFFICE USE ONLY
(Main Credentialing & Privileging Committee)

7.1 Recommendation for procedures requested

List of procedures	Recommendation		Remarks
	Yes	No	

____

Chairman of Main Credentialing
& Privileging Committee
( )

____

Director of Medical Practice Division
Ministry of Health Malaysia
( )

____
Date

____
Date