SENARAI SEMAK

Sila tandakan √ jika berkenaan

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 Lawatan Klinikal Anestesiologi. ☐
2. Salinan Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Penolong Pegawai Perubatan yang disahkan - (tahun semasa).* ☐
3. Salinan Sijil Diploma/ Ijazah Pembantu Perubatan yang diiktiraf oleh Lembaga Pembantu Perubatan. ☐
4. Salinan sijil Pos Basik *Intensive Care Nursing/ Advanced Diploma in Intensive Care Technologist* yang disahkan**;** @ ☐
5. Salinan Sijil Lulus *Advanced Life Support* (ALS). ☐
6. Ringkasan buku log lengkap diisi oleh pemohon dan disahkan oleh Ketua Jabatan/ Pakar Lawatan Klinikal Anestesiologi bagi yang tidak mempunyai pos basik *Intensive Care Nursing/ Advanced Diploma in Intensive Care Technologist.* ☐
7. Gambar ukuran passport dengan beruniform lengkap. ☐

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

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

Alamat untuk menghantar Borang Permohonan :

1) PENOLONG PEGAWAI PERUBATAN

KETUA PENOLONG PEGAWAI PERUBATAN
LEMBAGA PEMBANTU PERUBATAN
BAHAGIAN AMALAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA
ARAS 2, BLOK E1, KOMPLEKS E, PERSINT 1
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62590 PUTRAJAYA
Tel : 03 8883 1370
Faks : 03 8883 1490

TANDATANGAN
Di semak oleh :.....
(Cop Nama 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
  - ☐ 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

☐ 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)

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.

SUMMARY OF ASSISTANT MEDICAL OFFICER PROGRESS ON CLINICAL PRACTICE RECORDS FOR INTENSIVE CARE

Name : ……..

No. I/C :…….

SKILL	CORE PROCEDURES	REQUIRED			DONE			REMARKS
		O	A	P	O	A	P	
1	CLEANING, DECONTAMINATION & STERILIZATION OF MEDICAL AND NON-MEDICAL APPARATUS	1	1	4				
2	APPLYING PULSE OXIMETER & ITS CLINICAL APPLICATION	1	1	4				
3	APPLYING CAPNOMETER & ITS CLINICAL APPLICATION	1	1	4				
4	APPLYING REBREATHING / NON-REBREATHING MAS	1	1	4				
5	TESTING AND ASSEMBLING REUSABLE / DISPOSABLE VENTILATOR CIRCUITS	1	1	8				
6	SETTING AND CHANGE BASIC VENTILATOR PARAMETERS	1	1	8				
7	IDENTIFY AND TROUBLESHOOT VENTILATORS	2	2	6				
8	IDENTIFY AND TROUBLESHOOT MONITORS & DEFIBRILLATORS	2	2	6				
9	MAINTENANCE, CALIBRATION & QUALITY CONTROL OF ARTERIAL BLOOD GAS MACHINE	2	2	6				
10	SET-UP TRANSPORT VENTILATOR	2	2	6				
11	MANAGEMENT OF INVASIVE VENTILATORS AND ACCESSORIES	2	2	6				
12	MANAGEMENT OF NON - INVASIVE VENTILATORS AND ACCESSORIES	2	2	6				
13	APPLYING FULL BARRIER PERSONNEL PROTECTIVE EQUIPMENTS WITH N95 RESPIRATOR	1	1	4				
14	TRANSPORT OF CRITICALLY-ILL PATIENT	2	2	9				
15	PREPARATION, ASSEMBLE, FUNCTION TESTING & PERFORMING BAG-VALVE MASK	1	1	8				
16	PREPARATION AND ASSISTING IN ENDOTRACHEAL INTUBATION	2	2	6				
17	PREPARATION AND ASSISTING IN FLEXIBLE FIBREOPTIC BRONCHOSCOPY	2	2	8				
18	PREPARATION AND ASSISTING DIFFICULT INTUBATION	2	2	4				
19	PREPARATION AND ASSEMBLING ACTIVE HUMIDIFICATION SYSTEM	2	2	6				
20	PREPARATION AND ASSEMBLING PASSIVE HUMIDIFICATION SYSTEM	2	2	4				
21	PREPARATION PRESSURE TRANSDUCER SYSTEM AND ITS CLINICAL APPLICATION	2	2	6				
22	PERFORM TRACHEO-BRONCHIOL SUCTIONING - OPEN METHOD	2	2	4				
23	PERFORM TRACHEO-BRONCHIOL SUCTIONING - CLOSED METHOD	2	2	6				
24	PERFORM PRE-USE CHECK ON NON - INVASIVE VENTILATOR	2	2	6				
25	PERFORM PRE-USE CHECK ON INVASIVE VENTILATOR	2	2	6				
26	PERFORM CHECKING ON PORTABLE OXYGEN SYSTEM	1	1	6				
27	ADMINISTRATION OF AEROSOLIZED DRUGS VIA METERED-DOSE-INHALER OR NEBULIZER	1	1	8				
TOTAL CORE PROCEDURES		**44**	**44**	**159**				

SKILL	OPTIONAL PROCEDURES	REQUIRED			DONE			REMARKS
		O	A	P	O	A	P	
28	PREPARATION AND ASSISTING NON-INVASIVE CARDIAC OUTPUT MONITORING	1	1	4				
29	PREPARATION AND ASSISTING INVASIVE CARDIAC OUTPUT MONITORING	1	1	4				
30	PREPARATION AND ASSISTING PERCUTANEOUS TRACHEOSTOMY	1	1	4				
31	PREPARE, SET-UP AND CALIBRATION HIGH FREQUENCY OSCILLATORY VENTILATOR	1	1	4				
32	PREPARE AND ASSIST ON INTRA-CRANIAL PRESSURE MONITORING	1	1	4				
33	PREPARE AND ASSIST BRAIN STEM FUNCTION TEST	1	1	4				
34	PERFORM ECHOCARDIOGRAM	1	1	4				
35	PREPARATION AND PERFORM CONTINUOUS RENAL REPLACEMENT THERAPHY (CRRT)	1	1	4				
36	PREPARATION FOR LEVEL OF CONSCIOUSNESS MONITORING (BIS / NMT)	1	1	4				
TOTAL OPTIONAL PROCEDURES		**10**	**10**	**40**				

** OPTIONAL PROCEDURES (Since this procedure is not common at District Hospital, compulsory attachment for procedures at state hospital are require OR assessment by oral testing and demonstration of steps to the assessor is accepted with approval from Head of Department)*

COMMENTS:……
……..
……..
……..

Signature of Assessor

……..
(Name/ stamp)

Verified by HOD/ Visiting Anaesthesiologist

……
(Name/ stamp)