

## SENARAI SEMAK

Sila tandakan  jika berkenaan:-

1. Borang **APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE Rcred 1 - (2018)** perlu 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)* Kejururawatan / Penolong Pegawai Perubatan yang disahkan – (tahun semasa)\*
3. Salinan Sijil *Credentialing* yang bakal tamat tempoh.

**Nota :** \*Borang permohonan bagi Memperbaharui Sijil Credentialing mesti dipohon dan dihantar 6 (enam) bulan sebelum tarikh tamat tempoh Sijil Credentialing.

\*\*Sijil Credentialing tamat tempoh yang melebihi 1 tahun perlu membuat permohonan baru.

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

Borang Permohonan Memperbaharui Sijil *Credentialing* boleh dimuat turun dari portal KKM: [www.moh.gov.my](http://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)

Tel :

**APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE**

Name of Hospital : .....

Name of Applicant: .....

Identity Card No : .....

Position : .....

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

- |  |  |
|--|--|
| <input type="checkbox"/> Perioperative Care                        | <input type="checkbox"/> Orthopaedic Services          |
| <input type="checkbox"/> Ophthalmology                             | <input type="checkbox"/> Endoscopy Services            |
| <input type="checkbox"/> Emergency Medicine & Trauma Services      | <input type="checkbox"/> Cardiovascular Perfusion      |
| <input type="checkbox"/> Intensive Care Nursing                    | <input type="checkbox"/> Peri-Anaesthesia Care (P.A.C) |
| <input type="checkbox"/> Dialysis Care:                            | <input type="checkbox"/> Diagnostic Radiography        |
| <input type="checkbox"/> Haemodialysis                             | <input type="checkbox"/> Radiation Therapy             |
| <input type="checkbox"/> Peritoneal Dialysis                       | <input type="checkbox"/> Physiotherapy                 |
| <input type="checkbox"/> Anaesthesiology & Intensive Care Services | <input type="checkbox"/> Occupational Therapy          |
| <input type="checkbox"/> Anaesthesia                               | <input type="checkbox"/> Dental Technology             |
| <input type="checkbox"/> Peri-anaesthesia                          | <input type="checkbox"/> Optometry                     |
| <input type="checkbox"/> Intensive Care                            | <input type="checkbox"/> Dietetic                      |
| <input type="checkbox"/> General Paediatric Nursing                | <input type="checkbox"/> Speech Language Therapy       |
| <input type="checkbox"/> Neonatal Nursing                          | <input type="checkbox"/> Audiology                     |
| <input type="checkbox"/> Pre Hospital Care Services                |  |

Presently Credentialed from ..... till .....

Present Credentialing Certificate No.: .....

Current APC No.: .....

**PLACE OF WORK SINCE OBTAINING CREDENTIALING CERTIFICATE**

Please use additional sheets for extra space

| Hospital | Place of work | Duration<br>( From – Till ) |
|----------|---------------|-----------------------------|
|          |               |                             |
|          |               |                             |
|          |               |                             |
|          |               |                             |

**DECLARATION**

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

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

**RECOMMENDATION BY HEAD OF DEPARTMENT/ UNIT**

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

recommended  
 not recommended.

..... Date : .....

Signature

Official stamp :

**DECISION OF SPECIALTY SUB-COMMITTEE (SSC)**

This application is  Approved  Deferred\*  Rejected\*

\*Reasons: .....

.....

.....

Signature ..... Date .....

The above decision will be forwarded to the National Credentialing Committee (NCC) meeting for endorsement.