SENARAI SEMAK

Sila tandakan √ jika berkenaan

1. Borang Permohonan *APPLICATION FOR CREDENTIALING* - ***Cred 1- (2018)*** diisi dengan lengkap oleh pemohon dan ditandatangani oleh Ketua Jabatan/ Pakar Lawatan Klinikal ☐
2. Salinan Perakuan Pendaftaran Tahunan *Annual Practicing Certificate* (APC) Kejururawatan. (tahun semasa) ☐
3. Salinan sijil Pos Basik/ Pengkhususan Perawatan Neonatalogi ☐
4. Salinan sijil Neonatal Resuscitation Program (NRP) ☐
5. Gambar beruniform berukuran passport. ☐
6. Ringkasan buku log disahkan oleh Ketua Jabatan/ Pakar Lawatan Klinikal *(bagi yang tiada pos basik berkaitan).* ☐

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

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

Alamat untuk menghantar Borang Permohonan :

1) JURURAWAT

PENGARAH
BAHAGIAN KEJURURAWATAN
KEMENTERIAN KESIHATAN MALAYSIA
LOBI 3, ARAS 3, BLOK E7, KOMPLEKS E, PERSINT 1
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62590 PUTRAJAYA

Tel : 03 8883 3543/3544
Faks : 03 8890 4149

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
- ☐ Ophthalmology
- ☐ Emergency Medicine &Trauma Services
- ☐ Dialysis Care ☐ Haemodialysis
  ☐ Peritoneal Dialysis
- ☐ Anaesthesiology & Intensive Care Services
  - ☐ i. Anaesthesia
  - ☐ ii. Peri-anaesthesia
  - ☐ iii. Intensive Care
- ☐ 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 NURSES PROGRESSCLINICAL PRACTICE RECORD FOR NEONATALOGY

No	CORE PROCEDURES	Required	Done	Remark
1.	Admission of newborn	10		
2.	Clinical assessment of neonate	10		
3.	Anthropometric measurements	10		
4.	Thermoregulation of newborn	10		
5.	Stabilisation and transfer of neonate	3		
6.	Discharge of newborn	10		
7.	Application of pulse oximeter and interpretation of oxygen saturation	5		
8.	Setting up invasive blood pressure monitoring	2		
9.	Use of cardiorespiratory monitor and alarm limit setting	10		
10.	Heel prick	10		
11.	Incubator care (including disinfection)	5		
12.	Care of neonate in basic incubator	5		
13.	Care of neonate in humidified incubator	2		
14.	Weaning neonate from incubator	5		
15.	Use of radiant warmer – manual	5		
16.	Use of radiant warmer – servo-controlled	5		
17.	Phototherapy	10		
18.	Checking photolight irradiance	10		
19.	Administration of nasal prong oxygen	5		
20.	Setting up conventional ventilator	10		
21.	Care of baby on conventional ventilator	10		
22.	Setting up non-invasive ventilator	10		
23.	Care of baby on non-invasive ventilator	10		
24.	Blood gas interpretation	5		
25.	Assist in umbilical venous and arterial cannulation	5		
26.	Assist in peripherally inserted central catheter placement	5		
27.	Care of central line	10		
28.	Setting up total parenteral nutrition	10		
29.	Blood sampling from arterial line	5		
30.	Education on collection and storage of expressed breast milk	10		
31.	Handling of expressed breast milk and formula milk	10		
32.	Cup/spoon feeding	10		

33.	Enteral tube feeding	10		
34.	Administration of medication	10		
35.	Monitoring of patient under sedation	10		
36.	Bag valve mask resuscitation	10		
37.	Suctioning – oro/nasopharyngeal	10		
38.	Assist in intubation	10		
39.	Endotracheal tube suction - open	10		
40.	Endotracheal tube suction - closed	6		
41.	Extubation of patient	10		
42.	Assist lumbar puncture	2		
43.	Blood transfusion	3		
44.	Prepare infant for retinopathy of prematurity screening	6		

COMMENTS BY ASSESSSOR / HEAD OF DEPARTMENT:

……

……

……

Signature of Assessor:

…….

(Name / Stamp)

Date:

Verified by Head OF Department:

……

(Name / Stamp)

Date:

SUMMARY OF NURSES PROGRESS CLINICAL PRACTICE RECORD FOR NEONATOLOGY

No	OPTIONAL PROCEDURES	Done	Required	Remark
1.	Use of transcutaneous bilirubinometer	6		
2.	Use of transcutaneous carbon dioxide monitor	3		
3.	Setting up high frequency ventilator	6		
4.	Care of neonate on high frequency ventilation	6		
5.	Care of neonate on inhaled nitric oxide	3		
6.	Care of newborn undergoing hypothermia therapy	3		
7.	Stoma care	6		
8.	Care of patient with tracheostomy	3		
9.	Assist chest tube placement	3		
10.	Care of patient with chest tube	3		
11.	Newborn Hearing Screening	6		
12.	Preparation and assisting in exchange transfusion	2		
13.	Administration of oral sedation	3		
14.	Administration of medication by rectal route	2		

COMMENTS BY ASSESSSOR / HEAD OF DEPARTMENT:
……
……
……
……

Signature of Assessor:

……
……
(Name / Stamp)
Date:

Verified by Head OF Department:

(Name / Stamp)
Date: