

SENARAI SEMAK

Sila tandakan jika berkenaan:-

1. Borang **APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE – Rcred 1 (2018)** perlu diisi dengan lengkap oleh pemohon dan ditandatangani oleh Ketua Jabatan/ Pakar Lawatan Klinikal
2. Salinan Perakuan Pendaftaran Tahunan *Annual Practicing 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.– **Credentialing Assistant Medical Officer & Nurse**

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

2) JURURAWAT

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

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

Di semak oleh : ^{TANDATANGAN}.....
(Cop Nama Penyelia)

No. 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 | <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"/> 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 (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:

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Signature Date

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