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) Jururawat/ Penolong Pegawai Perubatan yang disahkan - (tahun semasa)* ☐

3. Salinan Sijil Diploma/ Ijazah Pembantu Perubatan @ Jururawat yang diiktiraf oleh Lembaga Pembantu Perubatan/ Lembaga Jururawat Malaysia ☐

4. Salinan Sijil Yang Disahkan:- ☐

   4.1 Pos Basik Perawatan Oftalmologi

5. Gambar beruniform berukuran passport. ☐

6. Ringkasan buku log disahkan oleh Ketua Jabatan/ Pakar Lawatan Klinikal ☐

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) 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

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 OPHTHALMIC CLINICAL PROCEDURES
CLINICAL PRACTICE RECORD

Name :_____

Hospital :_____ Date :_____

No.	Procedure	No Of Procedures Performed (Minimum Number)	Supervisor's Comments
1.	Triaging	30	
2.	Measurement of Visual Acuity (Adult)	5	
3.	Measurement of Visual Acuity (Children)	5	
4.	Measurement of near vision	5	
5.	Eye Examination (Anterior segment)	5	
6.	IOP measurement and calibration using Tonopen	10	
7.	Pre-operative counselling	10	
8.	Perform Schirmer's test	4	
9.	Color vision testing – ishihara	5	
10.	Eyelid hygiene (Eye lid scrub)	5	
11.	Eye dressing (First dressing)	10	
12.	Instilling eye drop with punctal occlusion	10	
13.	Application of eye pad and eye shield	10	
14.	Insertion and removal of bandage contact lens	2	
15.	Counseling on contact lens wear	2	
16.	Insertion and removal of eye prosthesis	2	
17.	Perform eye rodding	2	
18.	Perform pH testing of tears	5	
19.	Perform eye irrigation	2	
20.	Perform corneal staining	5	
21.	Perform fundus photography	20	
22.	Perform conjunctival swab	2	
23.	Prepare and assist in corneal scrapping	2	
24.	Preparation and assist in ROP screening	5	
25.	Prepare and assist in laser therapy	5	

26.	Prepare and assist in FFA (if service available)	5	
27.	Prepare and assist in syringing of lacrimal drainage system	2	
28.	Prepare and assist in incision and curettage	2	
29.	Prepare and assist in intravitreal injection (If service available)	10	

COMMENTS BY ASSESSSOR / HEAD OF DEPARTMENT:

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Signature of Assessor:

……

(Name / Stamp)

Date:

Verified by Head OF Department:

……

(Name / Stamp)

Date:

SUMMARY OF OPHTHALMIC SURGICAL PROCEDURES
CLINICAL PRACTICE RECORD

Name :_____

Hospital :_____ Date :_____

No.	Procedure	No Of Procedures Performed (Minimum Number)	Supervisor's Comments
1.	Cleaning and sterilization of microsurgical instruments	20	
2.	Prepare and assist in ECCE	5	
3.	Prepare and assist in phacoemulsification	20	
4.	Prepare and assist in pterygium excision	5	
5.	Prepare and assist in vitreoretinal surgery (If service available)	3	
6.	Preparation of intraocular gases for tamponade (If service available)	3	
7.	Prepare and assist in Trabeculectomy / GDD surgery (If service available)	1	
8.	Prepare and assist in corneal transplantation	1	
9.	Prepare and assist in oculoplastic surgery (If service available)	1	
10.	Prepare and assist in squint surgery (If service available)	1	

COMMENTS BY ASSESSSOR / HEAD OF DEPARTMENT:

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Signature of Assessor: Verified by Head OF Department:

…… ……

(Name / Stamp) (Name / Stamp)

Date: Date: