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

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

TANDATANGAN
Di semak oleh :.....
(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*) :

[ ] Perioperative
[ ] Ophthalmology
[ ] Emergency Medicine & Trauma Services
[ ] Intensive Care Nursing
[ ] Dialysis Care:
  [ ] Haemodialysis
  [ ] Peritoneal Dialysis
[ ] Anaesthesiology & Intensive Care Services
  [ ] Anaesthesia
  [ ] Peri-anaesthesia
  [ ] Intensive Care
[ ] Paediatric Nursing
[ ] Neonatal Nursing
[ ] Pre Hospital Care Services
[ ] Orthopaedic Services
[ ] Endoscopy Services
[ ] Cardiovascular Perfusion
[ ] Peri-Anaesthesia Care (P.A.C)
[ ] Diagnostic Radiography
[ ] Radiation Therapy
[ ] Physiotherapy
[ ] Occupational Therapy
[ ] Dental Technology
[ ] Optometry
[ ] Dietetic
[ ] Speech Language Therapy
[ ] Audiology

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.

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:

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(Name / Stamp)

Date:

Verified by Head OF Department:

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(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: