SENARAI SEMAK

Sila tandakan √ jika berkenaan

1. Borang permohonan baru ***APPLICATION FOR CREDENTIALING*** **Cred 1- (2018)** diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan serta ditandatangani oleh Ketua Jabatan/ Pakar Lawatan Klinikal Kecemasan. ☐

2. Salinan Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Jururawat / Penolong Pegawai Perubatan yang disahkan (tahun semasa)* ☐

3. Salinan Sijil Perakuan Pendaftaran Pembantu Perubatan/ Jururawat ☐

4. Salinan Sijil Yang Disahkan:-

   4.1 Sijil lulus BLS ☐

   4.2 MTLS/ ATLS/ TLS yang diiktiraf setaraf oleh NCORT; @ ☐

   4.3 Pos Basik AEMTC /ADEC atau Sarjana Muda Sains Perubatan Kecemasan ☐

5. Gambar beruniform berukuran passport. ☐

6. Borang *Grading For Credentialing in Emergency Services* (***Appendix B***) untuk pemohon *Emergency Medicine & Trauma Services* (EMTS). ☐

7. Ringkasan buku log disahkan oleh Ketua Jabatan/ Pakar Lawatan Klinikal Kecemasan *(bagi yang tiada pos basik berkaitan).* ☐

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

Borang Permohonan Baru *Credentialing* boleh dimuat turun dari portal KKM: 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

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)

Cred 1 - (2018)

APPLICATION FOR CREDENTIALING

HOSPITAL: ________________________________

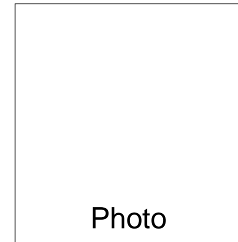
DATE OF APPLICATION: ____________________

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 Care ☐ Ophthalmology ☐ Emergency Medicine &Trauma Services ☐ Dialysis Care ☐ Haemodialysis ☐ Peritoneal Dialysis ☐ Anaesthesiology & Intensive Care Services ☐ i. Anaesthesia ☐ ii. Peri-anaesthesia ☐ iii. Intensive Care ☐ General 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	☐ Optional Procedures
a)…………………………………..	a) ………………………………………..
b)…………………………………..	b) ………………………………………..
c)…………………………………..	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* ☐

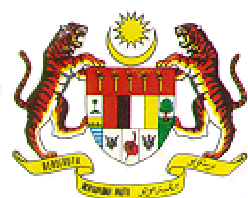
Application Rejected* ☐

*Reasons:
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

Specialty Sub-Committee Chairman ………………………… Date……………………
Signature

The above decision will be brought to the next NCC meeting for endorsement.

Appendix B



GRADING FOR CREDENTIALING IN EMERGENCY SERVICES

No.	Criterias	0	1	2	3	4	5
1.	Current medical knowledge						
2.	Leadership qualities						
3.	Professional clinical judgement						
4.	Sense of clinical responsibility						
5.	Ethical conduct						
6.	Clinical skill						
7.	Cooperativeness, ability to work with others						
8.	Teaching skill						
9.	*AHP-patient relationship						
10.	*AHP-physician understanding						
11.	Compliance with hospital rules and regulations						
12.	Personality						
13.	Research and development/Publication						
14.	Pre hospital Care						
15.	Medical standby/Disaster management						
Grand Total							

Grading	Credentialing Eligibility
Less than 15	Not qualified
16 - 25	Pending
26 - 59	Qualified
60 and above	Qualified with excellent

*AHP = Allied Health personnel

Comment : ………
………
………

……………………………………………….

Signature

Head of Department (HOD)/ Visiting EP

SUMMARY OF STAFF'S PROGRESS *CLINICAL PRACTICE RECORDS* FOR EMTS

*** Note : This Summary clinical practice record has been completed by the staff**

Name :____

I/C No :____

NO	Procedure	Required			Done			Remarks
		O	A	P	O	A	P	
1	**Triage**							
	1.1 Hospital Triage	10		10				
	1.2 Field Triage	1		10				
2	**Airway Management**							
	2.1 Insertion of Airway Adjunct	3		10				
	2.2 Insertion of Supraglotic Devices	3	5	10				
	2.3 Perform Tracheal Bronchial Suctioning	3	5	10				
	2.4 Prepare And Assist Endotracheal Intubation	3	5	10				
	2.5 Perform And Assist Emergency Cricothyrotomy	3	3					
3	**Ventilation & Oxygen Therapy**							
	3.1 Bag Valve Mask Ventilation	5		10				
	3.2 Assemble, Test, Set And Change Parameters Of Ventilator	5	5	10				
	3.3 Assess The Severity Of Acute Bronchial Asthma / Coad	5	5	10				
	3.4 Prepare, Prescribe And Administer Nebulisers	5	5	10				
	3.5 Administration Of Oxygen Therapy	5	5	10				
4	**CIRCULATION**							
	4.1 Intravenous Cannulation	5		10				
	4.2 Preparation And Administration Of Emergency Drugs	5	5	10				
	4.3 Preparation, Prescribe And Administration of IV Fluids For Resuscitation	5	5	10				
	4.4 Preparation And Assist In CVP Line Insertion And Monitoring	1	3	3				
	4.5 Stab Arterial Blood Sampling	5	5	5				
5	**RESUSCITATION**							
	5.1 Perform And Interpretation Of ECG			10				
	5.2 Recognition Of Lethal Arrhythmias – VT, VT And Asystole			5				
	5.3 Application And Usage of Automated Externak Defibrillator	1	1	4				
	5.4 Cardioplumonary Resuscitation	1	5	5				
6	**SURGICAL PROCEDURES**							
	6.1 Removal of Superficial Foreign Body (Not Penetrating Muscle Layer)	2	2	3				
	6.2 Basic Syes Procedures – Irrigation And Staining	2	2	3				
	6.3 Basic ENT Emergency Procesures – Nasal Packing	2	2	3				
	6.4 Basic ENT Emergency Procedures-Foreign Body Removal	2	2	3				
	6.5 Toilet And Suturing	5	5	10				

NO	Procedure	Required			Done			Remarks
		O	A	P	O	A	P	
	6.6 Incision And Drainage of Superficial Abcess Of Limbs	2	2	3				
	6.7 Nail Avulsion	2	2	3				
	6.8 Prepare And Assist Chest Tube Insertion Or Pericardiocentesis	2	2					
7	**PATIENT CARE**							
	7.1 Care of patient On Chest Tube	2	2	3				
	7.2 Care Of Patient in Ventilator	2	2	3				
	7.3 Transport of Critically Ill Patient	2	2	3				
	MEDICO LEGAL							
	7.1 Assist In The Examination Of The OSCC Patient	2	2	3				
	7.2 Handling Of Medico legal Specimen	2	2	3				
	IMMOBILIZATION							
	7.1 Cervical Collar Application	5	5	10				
	7.2 Spine Immobilization	5	5	10				
	7.3 Extremity Immobilization	5	5	10				
	7.4 Application Of Pelvic Immobilizer	1	2	3				
	7.5 Perform Log-Roll	5		10				
	7.6 Plaster Of Paris Application And Care	1	3	3				
8	**OTHER**							
	8.1 Reduction of Simple Small Joint Dislocation	2	2	5				
	8.2 Wound Management	3	5	5				
	8.3 Handling of Amputated Limb	1	1	2				
	8.4 Bladder Catheterization	3	5	5				
	8.5 Stomach Wash Out	1	1	2				
	8.6 external Decontamination Procedure	1	1	2				
	8.7 Handling of Violent Patient	1	1	2				
	8.8 Perform Blood Crossmatch Sampling And SET-UP Of Transfusion	3	4	5				
	8.9 Assisting Normal Delivery And Care Of Newborn	1	2	3				

COMMENTS :

____

____

____

____

Signature of Assessor

Verified by Head of Department (HOD)/ Visiting EP

……………………………………………

(Name / Stamp)

……………………………………

(Name / Stamp)

Date :