

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 Perunding Nefrologi) @ Pakar Perunding Lawatan Klinikal Nefrologi.
2. Salinan Diploma Jururawat/ Pembantu Perubatan yang disahkan oleh penyelia.
3. Salinan Perakuan Pendaftaran Tahunan *Annual Practising Certificate (APC)* Jururawat / Penolong Pegawai Perubatan yang disahkan - (tahun semasa).*
4. Salinan Sijil Pos Basik / Diploma Lanjutan Perawatan Renal yang disahkan.
5. Gambar ukuran passport dengan beruniform lengkap.
6. Ringkasan buku log disahkan oleh Ketua Jabatan (Pakar Perunding Nefrologi @ Pakar Perunding Lawatan Klinikal Nefrologi).

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)

APPLICATION FOR CREDENTIALING

HOSPITAL: _____

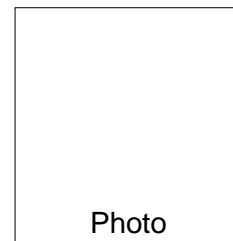
DATE OF APPLICATION: _____

1. PERSONAL DETAILS

Name:

Identification Card Number:

Area/ Discipline/ Specialty:



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

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Intensive Care Nursing <input type="checkbox"/> Peri-Operative Care <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Emergency Medicine & Trauma Services <input type="checkbox"/> Dialysis Care <input type="checkbox"/> Haemodialysis
 <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Anaesthesiology & Intensive Care Services <ul style="list-style-type: none"> <input type="checkbox"/> i. Anaesthesia <input type="checkbox"/> ii. Peri-anaesthesia <input type="checkbox"/> iii. Intensive Care <input type="checkbox"/> General Paediatric Nursing <input type="checkbox"/> Neonatal Nursing <input type="checkbox"/> Orthopaedic Services <input type="checkbox"/> Endoscopy Services <input type="checkbox"/> Peri-Anaesthesia Care (P.A.C) | <ul style="list-style-type: none"> <input type="checkbox"/> Cardiovascular Perfusion <input type="checkbox"/> Pre Hospital Care Services <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Diagnostic Radiography <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Dental Technology <input type="checkbox"/> Speech Language Therapy <input type="checkbox"/> Dietetic <input type="checkbox"/> Audiology <input type="checkbox"/> Optometry |
|---|---|

6.1 Credentialling applied for : Core Procedures

- | | |
|--|--|
| <input type="checkbox"/> Specialised Procedures in | <input type="checkbox"/> 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

Signature

Date.....

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

**SUMMARY OF STAFF'S PROGRESS *CLINICAL PRACTICE RECORDS* FOR
PERITONEAL DIALYSIS**

Name :

No. I/C :

**Note : This summary Clinical Practice Record Book has to be prepared at the end of each month.*

No	Procedure	Required			Done			Remarks
		O	A	P	O	A	P	
1.	Assessment Of Patient (And/Or Assistant) For Peritoneal Dialysis Treatment	2	3	10				
2.	Care Of Pd Catheter Pre- And Post-Operatively	2	3	10				
3.	Flushing Of PD Catheter	2	3	10				
4.	PD Prescription	2	3	10				
5.	Continuous Ambulatory Peritoneal Dialysis (CAPD) Training	2	3	10				
6.	Automated Peritoneal Dialysis (APD) Training	2	3	10				
7.	Application And Change Of Transfer Set	2	3	10				
8.	Exit Site Care	2	3	10				
9.	Management Of Peritonitis	2	3	10				
10.	Peritoneal Equilibration Testing (PET)	5	5	5				
11.	Assessment Of Dialysis Adequacy	2	3	10				
12.	PD Effluent Sampling For Microbiological Testing	2	3	10				
13.	Obtaining Swab Samples Frm Exit Site And Tunnel Infections	2	3	10				
14.	Nasal Swab Sampling For Culture	2	3	5				
15.	Intraperitoneal Antibiotic Administration	2	3	10				
16.	Parenteral Iron Administration	2	3	5				

**SUMMARY OF STAFF'S PROGRESS *CLINICAL PRACTICE RECORDS* FOR
PERITONEAL DIALYSIS**

Name :

No. I/C :.....

***Note : This summary Clinical Practice Record Book has to be prepared at the end of each month.**

No	Procedure	Required			Done			Remarks
		O	A	P	O	A	P	
17.	Home Visits	2	3	5				
18.	Handling Of Pd Effluent In Patients With Infective Risk (Hepatitis B, Hepatitis C Or Hiv)	1	1	1				
19.	Calculation And Reporting Of Pd Peritonitis Rates	2	3	5				

COMMENTS :

Signature of Assessor

.....

(Name / Stamp)

Date :

Verified by HOD

.....

(Name / Stamp)

Date :