gambar

MAKLUMAT PERIBADI PAKAR/PEGAWAI PERUBATAN
DI HOSPITAL-HOSPITAL
KEMENTERIAN KESIHATAN MALAYSIA

PROVIDER PROFILE

IC(New) :……………………………………………………………………………………
First Name :……………………………………………………………………………………
Last Name :……………………………………………………………………………………
Private Address :……………………………………………………………………………………
Postcode :……………………………………………………………………………………
City :……………………………………………………………………………………
State :……………………………………………………………………………………
Sex :……………………………………………………………………………………
Race :……………………………………………………………………………………
Date Of Birth :……………………………………………………………………………………
Age :……………………………………………………………………………………
Email :……………………………………………………………………………………
Phone(residence) :……………………………………………………………………………………
Cellular :……………………………………………………………………………………
Marital Status :……………………………………………………………………………………
Citizenship :……………………………………………………………………………………
Date Of Full Registration with MMC(date/m/year) :……………………………………………..

Date Of Appointment into service(date/m/year) :……………………………………………..

Number Of Full Registration :……………………………………………..

Date Of last Promotion(date/m/year) :……………………………………………..

Grade :…………………………………………………………………..

Spouse Name :…………………………………………………………………..
Occupation Of Spouse :…………………………………………………………………..
Office address Of Spouse :…………………………………………………………………..
:…………………………………………………………………..
:…………………………………………………………………..

CURRENT PLACEMENT

Department :……………………………………………………………………………………

Hospital / Institution :……………………………………………………………………………………

State :……………………………………………………………………………………

Types Of Service *(Please tick where appropriate)* :

- **State Hospital** ☐
- **District Hospital with specialist** ☐
- **District Hospital without specialist** ☐

Status Of Employment *(Please tick where appropriate)* :

- **Permanent** ☐
- **Contract** ☐

Staff Position *(Please tick where appropriate)* :

- **Senior Consultant** ☐
- **Consultant** ☐
- **Specialist** ☐
- **Medical Officer** ☐

BASIC MEDICAL TRAINING

Basic Degree

University/Medical School :…………………………………………………………

Year Of Qualification :…………………………………………………………

Housemanship

Place Of Housemanship Training :…………………………………………………………

(If more than 1 hospital please list other training center)

Place **Year**

1)…………………………………………………. ………………

2)…………………………………………………. ………………

Placement during Basic Medical Training

HOUSEMANSHIP

Discipline		Place	Duration(month)
Internal Medicine			
O&G			
Surgery			
Pediatric			
Orthopeadic			
Others(please list)			

MEDICAL OFFICER

Year :………to……….

Discipline		Place	Consultant	Duration(month)
Internal Medicine				
O&G				
Surgery				
Pediatric				
Orthopeadic				
Others(please list)				

POST GRADUATE TRAINING

Specialist Training

Year Of Qualification :……………………………………………………………………………………….
Qualification :……………………………………………………………………………………….
Discipline :……………………………………………………………………………………….
University /Awarding Body :……………………………………………………………………………………….
Undergoing gazettment training:

Yes ☐
Completed ☐

If yes, date of commencement of training:……………………………………………………………………………..

Date Of gazettment (date/m/year) :…………………………………………………………………………………..
Duration Of gazettment (month) :…………………………………………………………………………………..

Placement after completion of Specialist Training

Date (From….to…..) (d/m/year)	Hospital	Duration (months)

Fellowship Training(Subspecialty Training)
Are undergoing Training? **:Yes / No**
If Yes,
Discipline :…………………………………………………………………………………………………
Date Of Commencement of training :……………………………………………………………………………..
(date/m/year)
Training number, if applicable :……………………………………………………………………………………….
Place and duration of training that you have undergone

Date (From….to…..) (d/m/year)	Hospital	Name Of Trainer	Duration (months)

Any overseas training :………………………………………………………………………………….
If Yes,
Area Of Training :………………………………………………………………………………….
Place Of Training :………………………………………………………………………………….
Trainer :………………………………………………………………………………….
Period Of Training :………………………………………… to…………………………………………..
(date/m/year)

If you have completed training ,
Certifying Body :………………………………………………………………………………….
Date Of Completion :………………………………………………………………………………….
(date/m/year)
Date Of gazettment for :………………………………………………………………………………….
subspecialty if applicable
(date/m/year)

Placement after completion of Fellowship Training

Date (From….to…..) (d/m/year)	Hospital	Duration (months)