SENARAI SEMAK PERMOHONAN BAHARU *(CREDENTIALING) OPHTHALMOLOGY*
BAGI PROFESION PENOLONG PEGAWAI PERUBATAN DAN JURURAWAT

Sila tandakan √ jika berkenaan dalam kotak yang disediakan:

Bil.	Maklumat	Tandakan √
1.	Borang permohonan baru ***APPLICATION FOR CREDENTIALING*** **Cred 1- (2018)** diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan serta ditandatangan oleh:- **a. Hospital berpakar**: Ketua Jabatan Oftalmologi **b. Hospital tanpa pakar**: Pakar Lawatan Klinikal Oftalmologi	☐
2.	Ringkasan buku log yang ditandatangan oleh *assessor* dan disahkan oleh:- a. **Hospital berpakar**: Ketua Jabatan Oftalmologi b. **Hospital tanpa pakar**: Pakar Lawatan Klinikal Oftalmologi	☐
3.	Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	3.1 Perakuan Pendaftaran Sebagai Penolong Pegawai Perubatan / Jururawat	☐
	3.2 Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Penolong Pegawai Perubatan / Jururawat - (APC tahun terkini).*	☐
	3.3 Sijil Pos Basik Perawatan Oftalmologi (jika ada)	☐
4.	Gambar beruniform berukuran passport.	☐

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
CAW.PERKHIDMATAN PENOLONG PEGAWAI
PERUBATAN BAHAGIAN AMALAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA
ARAS 6, BLOK E1, KOMPLEKS E, PRESINT 1
PUSAT PENTADBIRAN KERAJAAN PUTRAJAYA
625920 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, PRESINT 1
PUSAT PENTADBIRAN KERAJAAN PUTRAJAYA
625920 PUTRAJAYA

Tel : 03 8883 3543/3544
Faks : 03 8890 4149

Di semak oleh :.....
(Cop Nama Penyelia)

No Telefon 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 Care
[ ] **Ophthalmology**
[ ] Emergency Medicine &Trauma Services
Dialysis Care : -
[ ] Haemodialysis
[ ] Peritoneal Dialysis
[ ] Anaesthesiology & Intensive Care Services :-
[ ] Anaesthesia
[ ] Peri-anaesthesia
[ ] Intensive Care
[ ] General Paediatric Nursing
[ ] Neonatal Nursing
[ ] Orthopaedic Services
[ ] Endoscopy Services
[ ] Peri-Anaesthesia Care (P.A.C)
[ ] General Paediatric Nursing

[ ] Cardiovascular Perfusion
[ ] Pre Hospital Care Services
[ ] Physiotherapy
[ ] Occupational Therapy
[ ] Diagnostic Radiography
[ ] Radiation Therapy
[ ] Dental Technology
[ ] Speech Language Therapy
[ ] Dietetic
[ ] Audiology

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 Ophthalmology Department)

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 Ophthalmology Department / Visiting Clinical Specialist)

……..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)	Number of Procedures Performed (Done)	Supervisor 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.	Preoperative counseling	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 (if service available)	2		
29.	Prepare and assist in intravitreal injection (If service available)	10		

COMMENTS :

_____

_____

Signature of Assessor

Verified by Head of Ophthalmology Department / Visiting Clinical Specialist

…… ……

(Name / Stamp) (Name / Stamp)

Date : Date:

SUMMARY OF OPHTHALMIC SURGICAL PROCEDURES

CLINICAL PRACTICE RECORD

Name:_____

Hospital: _____ Date:_____

No.	Procedure	No Of Procedures Performed (Minimum Number)	Number of Procedures Performed (Done)	Supervisor 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 :

_____

_____

_____

Signature of Assessor

……

(Name / Stamp)
Date :

Verified by Head of Ophthalmology Department / Visiting Clinical Specialist

……

(Name / Stamp)
Date: