

SENARAI SEMAK PERMOHONAN BAHARU (*CREDENTIALING*) ANAESTHESIA BAGI PENOLONG PEGAWAI PERUBATAN

Sila tandakan jika berkenaan dalam kotak yang disediakan:

Bil.	Maklumat	Tandakan <input type="checkbox"/>
1.	Borang permohonan baru <i>APPLICATION FOR CREDENTIALING Cred 1- (2018)</i> diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan serta ditandatangani oleh:- a. Hospital berpakar: Ketua Jabatan Anestesiologi & Rawatan Rapi. b. Hospital tanpa pakar: Pakar Perunding Lawatan Klinikal Anestesiologi/ Pakar Anestesiologi Negeri.	<input type="checkbox"/>
2.	Ringkasan buku log yang ditandatangani oleh <i>assessor</i> dan disahkan oleh:- a. Hospital berpakar: Ketua Jabatan Anestesiologi. b. Hospital tanpa pakar: Pakar Perunding Lawatan Klinikal Anestesiologi/ Pakar Anestesiologi Negeri. (<i>Jika Berkaitan -sila rujuk kriteria/syarat permohonan</i>)*	<input type="checkbox"/>
3.	Salinan Sijil Perlu Disahkan Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	3.1 Perakuan Pendaftaran Sebagai Pembantu Perubatan/ Jururawat	<input type="checkbox"/>
	3.2 Perakuan Pendaftaran Tahunan <i>Annual Practising Certificate (APC)</i> Jururawat / Penolong Pegawai Perubatan - (APC tahun terkini).*	<input type="checkbox"/>
	3.3 Pos Basik <i>Anaesthesia</i>	<input type="checkbox"/>
4.	Gambar beruniform berukuran passport.	<input type="checkbox"/>

Borang Permohonan Baru *Credentialing* boleh dimuat turun dari portal KKM:
www.moh.gov.my – *Credentialing Assistant Medical Officer & Nurses*

Alamat untuk menghantar Borang Permohonan :

KETUA PENOLONG PEGAWAI PERUBATAN
 CAW. PERKHIDMATAN PENOLONG PEGAWAI PERUBATAN
 BAHAGIAN AMALAN PERUBATAN
 KEMENTERIAN KESIHATAN MALAYSIA
 ARAS 6, BLOK E1, KOMPLEKS E, PERSINT 1
 PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
 62590 PUTRAJAYA

Tel : 03 8883 1370
 Faks : 03 8883 1490

Disemak oleh:

No. Tel :

APPLICATION FOR CREDENTIALING

HOSPITAL: _____

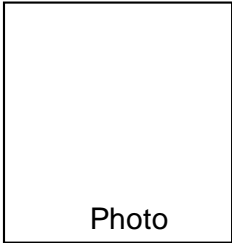
DATE OF APPLICATION: _____

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)

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 HOD Anaesthesiology & Intensive Care/ Visiting Anaesthesiologist/ State Anaesthesiologist)

.....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 ASSISTANT MEDICAL OFFICER PROGRESS ON CLINICAL PRACTICE RECORDS FOR
ANAESTHESIA**

Name :

No. I/C :

SKILL	CORE PROCEDURES	REQUIRED			DONE			REMARKS
		O	A	P	O	A	P	
1	CLEANING AND STERILIZATION OF ANAESTHETIC EQUIPMENT	1	2	5				
2	DECONTAMINATION OF ANAESTHETIC MACHINE AND MONITORS	1	2	5				
3	CHECKING OF ANAESTHETIC MACHINE BEFORE USE	1	2	5				
4	PRE-ANAESTHETIC ASSESSMENT	1	2	5				
5	FINAL ASSESSMENT FOR PATIENT IN OPERATION THEATRE	1	2	5				
6	PREPARATION OF ANAESTHETIC MACHINE AND EQUIPMENT	1	2	5				
7	PREPARATION OF ANAESTHETIC DRUGS	1	2	5				
8	PREPARATION OF PATIENT FOR ANAESTHESIA IN OPERATING THEATRE	1	2	5				
9	INDUCTION OF ANAESTHESIA	1	2	5				
10	ENDOTRACHEAL INTUBATION	1	2	5				
11	RAPID SEQUENCE INDUCTION	1	2	5				
12	EXPECTED DIFFICULT INTUBATION	1	2	5				
13	FAILED INTUBATION DRILL	1	1	1				
14	ENDOTRACHEAL EXTUBATION	1	2	5				
15	ADMINISTRATION OF GENERAL ANAESTHESIA (IPPV)	1	2	5				
16	GENERAL ANAESTHESIA (SPONTANEOUS - HOLD MASK)	1	2	5				
17	GENERAL ANAESTHESIA (SPONTANEOUS -SUPRAGLOTTIC AIRWAY)	1	2	5				
18	ADMINISTRATION OF TOTAL INTRAVENOUS ANAESTHESIA (TIVA)	1	2	5				
19	SPINAL ANAESTHESIA	1	2	5				
20	ADMINISTRATION OF MONITORED SEDATION	1	2	5				
21	POST ANAESTHESIA CARE	1	2	5				
TOTAL CORE PROCEDURES		21	41	101				

SKILL	OPTIONAL PROCEDURES	REQUIRED			DONE			REMARKS
		O	A	P	O	A	P	
22	ADMINISTRATION OF ANAESTHESIA FOR ELECTRO-CONVUSIVE THERAPY (ECT)	1	2	5				
23	CAUDAL BLOCK	1	2	5				
24	BRACHIAL PLEXUS NERVE BLOCK (SUPRACLAVICULAR APPROACH)	1	2	5				
25	BRACHIAL PLEXUS NERVE BLOCK (AXILLARY APPROACH)	1	2	5				
26	WRIST BLOCK	1	2	5				
27	FEMORAL NERVE BLOCK - ANTERIOR APPROACH	1	1	5				
28	SCIATIC NERVE BLOCK - POSTERIOR BLOCK	1	1	5				
29	ANKLE BLOCK	1	1	5				
CORE PROCEDURES		8	16	40				

** OPTIONAL PROCEDURES (Since this procedure is not common at District Hospital, compulsory attachment for procedures at state hospital are require OR assessment by oral testing and demonstration of steps to the assessor is accepted with approval from Head of Department)*

COMMENTS:.....
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Signature of Assessor

Verified by HOD Anaestehsilogy & Intensive Care/ Visiting Anaesthesiologist/ State Anaesthesiologist

.....
(Name/ stamp)

.....
(Name/ stamp)