**SENARAI SEMAK PERMOHONAN BAHARU (CREDENTIALING) *NEONATAL NURSING***

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:-<br>**a. Hospital berpakar**: Ketua Jabatan Pediatrik<br>**b. Hospital tanpa pakar**: Pakar Lawatan Klinikal Jabatan Pediatrik | ☐ |
| 2. | Ringkasan buku log yang ditandatangan oleh *assessor* dan disahkan oleh:-<br>a. **Hospital berpakar**: Ketua Jabatan Pediatrik<br>b. **Hospital tanpa pakar**: Pakar Lawatan Klinikal Jabatan Pediatrik<br>*(bagi yang tiada pos basik/ diploma lanjutan berkaitan)** | ☐ |
| 3. | Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):- | |
| | 3.1 Perakuan Pendaftaran Sebagai Jururawat | ☐ |
| | 3.2 Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Jururawat - (APC tahun terkini).* | ☐ |
| | 3.3 Sijil Neonatal Resuscitation Program | ☐ |
| | 3.4 Sijil Pos Basik Perawatan Neonatologi ( 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 :**

**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: …….<br>(example: Lembaga Jururawat Malaysia, Lembaga Pembantu Perubatan Malaysia, Majlis Optik Malaysia)<br><br>Date of Full Registration with respective professional Board / Council: ……..<br><br>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 Pediatric 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 Pediatric 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 NURSES PROGRESS CLINICAL PRACTICE RECORD**
**(CORE PROCEDURES)**

**NAME:**
**I/C NO:**

| No. | Procedures | Required | Done | Remarks |
|---|---|---|---|---|
| 1. | Admission of newborn | 10 | | |
| 2. | Clinical assessment of neonate | 10 | | |
| 3. | Anthropometric measurements | 10 | | |
| 4. | Thermoregulation of newborn | 10 | | |
| 5. | Stabilization and transfer of neonate | 3 | | |
| 6. | Discharge of newborn | 10 | | |
| 7. | Application of pulse oximeter and interpretation of oxygen saturation | 5 | | |
| 8. | Setting up invasive blood pressure monitoring | 2 | | |
| 9. | Use of cardiorespiratory monitor and alarm limit setting | 10 | | |
| 10. | Heel prick | 10 | | |
| 11. | Incubator care ( including disinfection) | 5 | | |
| 12. | Care of neonates in basic incubator | 5 | | |
| 13. | Care of neonates in humidified incubator | 2 | | |
| 14. | Weaning neonates from incubator | 5 | | |
| 15. | Use of radiant warmer – manual | 5 | | |
| 16. | Use of radiant warmer – servo-controlled | 5 | | |
| 17. | Phototherapy | 10 | | |
| 18. | Checking photo light irradiance | 10 | | |
| 19. | Administration of nasal prong oxygen | 5 | | |
| 20. | Setting up conventional ventilator | 10 | | |
| 21. | Care of baby on conventional ventilator | 10 | | |
| 22. | Setting up non-invasive ventilator | 10 | | |
| 23. | Care of baby on non-invasive ventilator | 10 | | |
| 24. | Blood gas interpretation | 5 | | |
| 25. | Assist in umbilical venous and arterial cannulation | 5 | | |
| 26. | Assist in peripherally inserted central catheter placement | 5 | | |
| 27. | Care of central line | 10 | | |
| 28. | Setting up total parental nutrition | 10 | | |
| 29. | Blood sampling from arterial line | 5 | | |

| No. | Procedures | Required | Done | Remarks |
|---|---|---|---|---|
| 30. | Education on collection and storage of expressed breast milk | 10 | | |
| 31. | Handling of expressed breast milk and formula milk | 10 | | |
| 32. | Cup/spoon feeding | 10 | | |
| 33. | Enteral tube feeding | 10 | | |
| 34. | Administration of medication | 10 | | |
| 35. | Monitoring of patient under sedation | 10 | | |
| 36. | Bag valve mask resuscitation | 10 | | |
| 37. | Suctioning – oro/nasopharyngeal | 10 | | |
| 38. | Assist in intubation | 10 | | |
| 39. | Endotracheal tube suction – open | 10 | | |
| 40. | Endotracheal tube suction – closed | 6 | | |
| 41. | Extubation of patient | 10 | | |
| 42. | Assist lumbar puncture | 2 | | |
| 43. | Blood transfusion | 3 | | |
| 44. | Prepare infant for retinopathy of prematurity screening | 6 | | |

**COMMENTS :**

_____

_____

_____

Signature of Assessor

…….
( Name / Stamp )
Date :

Verified by Head of Department /
Visiting Clinical Specialist

…….
( Name / Stamp )
Date :

**SUMMARY OF NURSES PROGRESS CLINICAL PRACTICE RECORD**

**(OPTIONAL PROCEDURES)**

| No. | OPTIONAL PROCEDURES | Required | Done | Remarks |
|---|---|---|---|---|
| 1. | Use of transcutaneous bilirubin meter | 6 | | |
| 2. | Use of transcutaneous carbon dioxide monitor | 3 | | |
| 3. | Setting up high frequency ventilator | 6 | | |
| 4. | Care of neonates on high frequency ventilation | 6 | | |
| 5. | Care of neonates on inhaled nitric oxide | 3 | | |
| 6. | Care of newborn undergoing hypothermia therapy | 3 | | |
| 7. | Stoma care | 6 | | |
| 8. | Care of patient with tracheostomy | 3 | | |
| 9. | Assist chest tube placement | 3 | | |
| 10. | Care of patient with chest tube | 3 | | |
| 11. | Newborn Hearing Screening | 6 | | |
| 12. | Preparation and assisting in exchange transfusion | 2 | | |
| 13. | Administration of oral sedation | 3 | | |
| 14. | Administration of medication by rectal route | 2 | | |

**COMMENTS:**

_____

_____

_____

Signature of Assessor

……

( Name / Stamp )
Date :

Verified by Head of Department /
Visiting Clinical Specialist

……

( Name / Stamp )
Date: