SENARAI SEMAK PERMOHONAN BAHARU (*CREDENTIALING*) HEMODIALISIS BAGI 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 Nefrologi. b. **Hospital tanpa pakar**: Pakar Perunding Lawatan Klinikal Nefrologi.	☐
2.	Ringkasan buku log yang ditandatangan oleh *assessor* dan disahkan oleh:- a. **Hospital berpakar**: Ketua Jabatan Nefrologi. b. **Hospital tanpa pakar**: Pakar Perunding Lawatan Klinikal Nefrologi.	☐
3.	Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	3.1 Perakuan Pendaftaran Sebagai Pembantu Perubatan/ Jururawat	☐
	3.2 Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Jururawat / Penolong Pegawai Perubatan - (APC tahun terkini).*	☐
	3.3 Pos Basik/ Diploma Lanjutan Perawatan Renal	☐
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, 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

Disemak oleh: ……..

No. Tel : ……

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
  - ☐ i. Anaesthesia
  - ☐ ii. Peri-anaesthesia
  - ☐ iii. Intensive Care
- ☐ General Paediatric Nursing
- ☐ Neonatal Nursing
- ☐ Orthopaedic Services
- ☐ Endoscopy Services
- ☐ Peri-Anaesthesia Care (P.A.C)
- ☐ Cardiovascular Perfusion
- ☐ Pre Hospital Care Services
- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Diagnostic Radiography
- ☐ Radiation Therapy
- ☐ Dental Technology
- ☐ Speech Language Therapy
- ☐ Dietetic
- ☐ Audiology
- ☐ Optometry

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 Haemodialysis Unit)

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 Nephrology @ Visiting Nephrologist)

……..…….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 STAFF'S PROGRESS *CLINICAL PRACTICE RECORDS* FOR HAEMODIALYSIS

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 For Hemodialysis Treatment	2	2	6				
2.	Care Of Arterio-Venous Fistula (Native And Graft)	2	2	10				
3.	Care Of Haemodialysis Catheter (Cuffed And Non- Cuffed)	2	2	12				
4.	Anti Coagulation Therapy	2	2	6				
5.	Preparation Of Haemodialysis Machine	2	2	5				
6.	Setting Up And Priming Of Dialyzer And Bloodline	2	2	10				
7.	Cannulation Technique	3	5	17				
8.	Initiation Of Haemodialysis Treatment	3	5	17				
9.	Termination Of Haemodialysis Treatment	3	5	17				
10.	Disinfection And Decalcification Of Haemodialysis Machine	2	2	5				
11.	Reprocessing Of Dialyzers	3	3	14				
12.	Management Of Intradialytic Complications		5	15				
13.	Identification Of Components And Functions Of Haemodialysis Machine	3	3	14				
14.	Monitoring And Management Of Water Treatment System	3	3	19				
15.	Parenteral Iron Administration	2	2	6				

SUMMARY OF STAFF'S PROGRESS *CLINICAL PRACTICE RECORDS* FOR HAEMODIALYSIS

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**	
16.	Management Of Erythropoeisis Stimulating Agents	2	2	11				
17.	Assessment Of Dialysis Adequacy	3	3	10				
18.	Vascular Access Recirculation Study	2	2	8				

O: Observe A: Assist P: Perform

COMMENTS :

_____

_____

_____

Signature of Assessor

……

(Name / Stamp)

Date :

Verified by HOD Nephrology @ Visiting Nephrologist

……

(Name / Stamp)

Date :