

1. Borang Pendaftaran AMOTeX

SENARAI SEMAK

Sila tandakan (√) pada yang berkenaan

1. Borang permohonan **AMOTeX APPLICATION FORM** yang lengkap perlu ditandatangani oleh **Ketua Penyelia** dan **Ketua Jabatan Klinikal / Pakar Kesihatan Keluarga**
2. Salinan **Perakuan Pembaharuan Tahunan (PPT)** Penolong Pegawai Perubatan yang disahkan (tahun semasa)
3. Salinan **Sijil Perakuan Pendaftaran Pembantu Perubatan** yang disahkan
4. Salinan **Sijil Pos Basik (PB)/ Diploma Lanjutan** yang disahkan
5. Salinan **Sijil Credentialing** terkini yang disahkan bagi Program Perubatan **ATAU** salinan **Rumusan Buku Log** bagi Program Kesihatan Awam.

Semua borang dan salinan sijil hendaklah dihantar dalam satu salinan sahaja

Alamat Penghantaran Borang Permohonan :

KETUA PENOLONG PEGAWAI PERUBATAN
CAWANGAN PERKHIDMATAN PENOLONG PEGAWAI PERUBATAN
BAHAGIAN AMALAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA
ARAS 6, BLOK E1, KOMPLEKS E,
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62590 PUTRAJAYA
WILAYAH PERSEKUTUAN PUTRAJAYA

Tel : 03 8883 1370

Di semak oleh:

(Tandatangan & Cop Penyelia)

AMOTeX APPLICATION FORM

HOSPITAL / DISTRICT HEALTH OFFICE (PKD) :

DATE OF APPLICATION :

1. PERSONAL DETAILS

1.1 Name :

1.2 I/C Number :

1.3 Office Address :

.....

.....

.....

1.4 Area/ Discipline/ Specialty:

1.5 Telephone Number: Office :

Mobile :

1.6 Email Address :

1.7 Date of first appointment : (DD/MM/YY)

1.8 Duration of service:years

1.9 Date of Full Registration with Medical Assistant Board :

1.10 Current Annual Renewal Certificate No.:

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 (Qualified)

(Please attach certified copies of certificates obtained, Please use attachment sheet if space inadequate)

4. WORKING EXPERIENCE

Discipline	Place	dd/mm/yy (from – till)	Duration

(Use attachment sheet if space inadequate)

5. AMOTeX APPLIED

- | | | | |
|-------------------------------------|--------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> | Cardiology | <input checked="" type="checkbox"/> | Neurosurgery |
| <input type="checkbox"/> | Cardiovascular Perfusion | <input checked="" type="checkbox"/> | Obstetrics & Gynecology |
| <input type="checkbox"/> | Cardiothoracic Surgery | <input checked="" type="checkbox"/> | Oncology |
| <input type="checkbox"/> | Emergency Medicine & Trauma Services | <input checked="" type="checkbox"/> | Otorhinolaryngology |
| <input type="checkbox"/> | Nephrology | <input checked="" type="checkbox"/> | Ophthalmology |
| <input type="checkbox"/> | Orthopaedic | <input checked="" type="checkbox"/> | Plastic & Reconstructive Surgery |
| <input type="checkbox"/> | Neurophysiology | <input checked="" type="checkbox"/> | Pre Hospital & Ambulance Services |
| <input type="checkbox"/> | Diabetes | <input checked="" type="checkbox"/> | Psychiatry & Mental Health |
| <input type="checkbox"/> | HIV/AIDS Counseling | <input checked="" type="checkbox"/> | Radiotherapy & Oncology |
| <input type="checkbox"/> | Wound Care Management | <input checked="" type="checkbox"/> | Respiratory |
| <input checked="" type="checkbox"/> | Anesthesiology & Intensive Care | <input checked="" type="checkbox"/> | Urology |
| <input checked="" type="checkbox"/> | Endoscopy | <input checked="" type="checkbox"/> | Adolescent Health Programs |
| <input checked="" type="checkbox"/> | Forensic Medicine | <input checked="" type="checkbox"/> | Elderly Health Programs |
| <input checked="" type="checkbox"/> | Nuclear Medicine | <input checked="" type="checkbox"/> | Epidemiology |
| <input checked="" type="checkbox"/> | Hand & Microsurgery | <input checked="" type="checkbox"/> | Men's Health Programs |
| <input checked="" type="checkbox"/> | Infection Control | <input checked="" type="checkbox"/> | Primary Health Care |
| <input checked="" type="checkbox"/> | Intensive Care | <input checked="" type="checkbox"/> | TB/Leprosy |

*Please **do not tick (✓)** on the black box. Only applicable for the 2nd phase of AMOTeX

6. NAME OF TWO REFEREES

NAME	POSITION	PLACE OF WORK

I hereby declare that all the information given above are true and correct.

Signature of applicant :

Date :

7. APPLICANT APPRAISAL [to be filled by AMO Supervisor (Department/unit)]

7.1 I have known the applicant for..... (duration)

7.2 I recommend / do not recommend the applicant for AMOTeX registration in the field requested.
(delete where applicable)

.....

Signature Official

Stamp :

Contact No :

Date :

8. APPLICATION APPROVAL [By Head of Department (Clinical) / FMS / PHMS]

..... is approved / not approved for submission to the AMOTeX Assessment Committee.

.....

Date :

Signature

Official stamp :

FOR OFFICIAL USE

AMOTEX ASSESSMENT COMMITTEE DECISION

Application Approved	<input type="checkbox"/>
For Reassessment*	<input type="checkbox"/>
Application Rejected*	<input type="checkbox"/>

*Reasons:

.....
.....
.....

AMOTeX Assessment Committee Chairman.

.....
Signature

Date.....

The above decision will be brought to the next Medical Assistant Board (MAB) meeting for endorsement