Borang Pendaftaran AMOTeX

SENARAI SEMAK

Sila tandakan (√) pada yang berkenaan

1. Borang permohonan ***AMOTeX APPLICATION FORM*** yang lengkap perlu ditandatangan 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 *Credentialing* terkini yang disahkan ☐

5. Salinan sijil Pos Basik (PB)/Diploma Lanjutan/Kursus yang berkaitan **ATAU** syarat pilihan (buku log bagi tiga bidang yang tiada PB (Kesihatan Awam) /latihan lanjutan yang disahkan. ☐

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
Faks : 03 8883 1490

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

☐	Cardiology	■	Neurosurgery
☐	Cardiology Perfusion	■	Obstetrics & Gynecology
☐	Cardiothoracic Surgery	■	Oncology
☐	Emergency Medicine & Trauma Services	■	Otorhinolaryngology
☐	Nephrology	■	Ophthalmology
☐	Orthopaedic	■	Plastic & Reconstructive Surgery
☐	Neurophysiology	■	Pre Hospital & Ambulance Services
☐	Diabetes	■	Psychiatry & Mental Health
☐	HIV/AIDS Counseling	■	Radiotherapy & Oncology
☐	Wound Care Management	■	Respiratory
■	Anesthesiology & Intensive Care	■	Urology
■	Endoscopy	■	Adolescent Health Programs
■	Forensic Medicine	■	Elderly Health Programs
■	Nuclear Medicine	■	Epidemiology
■	Hand & Microsurgery	■	Men's Health Programs
■	Infection Control	■	Primary Health Care
■	Intensive Care	■	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]

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

..... Date : .....

Signature

Official stamp :

FOR OFFICIAL USE

AMOTEX ASSESSMENT COMMITTEE DECISION

Application Approved ☐

For Reassessment* ☐

Application Rejected* ☐

*Reasons:

……

……

……

AMOTeX Assessment Committee Chairman.

…… Date……

Signature

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