1. Borang Pendaftaran AMOTeX

SENARAI SEMAK

Sila tandakan (√) pada yang berkenaan

1. Borang permohonan ***AMOTeX APPLICATION FORM*** yang lengkap. ☐
2. Salinan **Perakuan Pembaharuan Tahunan (PPT)** Penolong Pegawai Perubatan yang disahkan (tahun semasa). ☐
3. Salinan **Sijil Pos Basik / Diploma Lanjutan** yang disahkan. ☐
4. 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 Ketua Penyelia Hospital/ PKD/ PKK/ PKB)

PKD : Pejabat Kesihatan Daerah

PKK : Pejabat Kesihatan Kawasan

PKB : Pejabat Kesihatan Bahagian

AMOTeX APPLICATION FORM

HOSPITAL / DISTRICT HEALTH OFFICE (PKD/PKK/PKB) : ....

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

Area of AMOTeX applied for (*tick in the appropriate box*) :

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

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	☐
For Reassessment*	☐
Application Rejected*	☐

*Reasons:

……

……

……

AMOTeX Assessment Committee Chairman.

…………………………
Signature

Date……………………

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