**SENARAI SEMAK PERMOHONAN BAHARU (*CREDENTIALING*)**
***CARDIOLOGY* BAGI PENOLONG PEGAWAI PERUBATAN**

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 Ketua Jabatan/ Pakar Kardiologi. | ☐ |
| 2. | Ringkasan buku log yang ditandatangan oleh *assessor* dan disahkan oleh Ketua Jabatan / Pakar Kardiologi. | ☐ |
| 3. | Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):- | |
| | 3.1 Perakuan Pendaftaran Sebagai Pembantu Perubatan | ☐ |
| | 3.2 Perakuan Pembaharuan Tahunan Pembantu Perubatan *Annual Renewal Certificate* (ARC) - (ARC tahun terkini).* | ☐ |
| | 3.3 Diploma Lanjutan Perawatan Kesihatan Kardiovaskular (Teknologi)/ Sijil Pos Basik Coronary Care. | ☐ |
| 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 :**

KETUA PENOLONG PEGAWAI PERUBATAN
CAW. PERKHIDMATAN PENOLONG PEGAWAI
PERUBATANBAHAGIAN AMALAN PERUBATAN
KEMENTERIAN KESIHATAN
MALAYSIA ARAS 6, BLOK E1,
KOMPLEKS E, PERSINT 1
PUSAT PENTADBIRAN KERAJAAN
PERSEKUTUAN62590 PUTRAJAYA
Tel : 03 8883 1370/ 1374
Faks : 03 8883 1490

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 : ……<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
  - ☐ 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
- ☐ **Cardiology**: Non-Invasive Cardiology (NICL)
  - i. ☐ Transthoracic Echocardiography (TTE)
  - ii. ☐ Exercise Stress Test
  - iii. ☐ Holter
- ☐ **Cardiology:** Invasive Cardiology (ICL)
- ☐ **Cardiology**: Cardiac Rhythm Management & Electrophysiology

6.1 Credentialling applied for : ☐ Core Procedures

☐ Specialised Procedures in ☐ Optional Procedures

| | |
|---|---|
| a)…….. | a) …….. |
| b)…….. | b) …….. |
| c)…….. | 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)**

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)**

….....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.

PROGRESS REPORT
CLINICAL PRACTICE RECORD

Name :.....

No. I/C :…….

Month : …….

*Note: This summary clinical practice record has to be prepared at the end of each month.

**POLICY AND PROCEDURES ON TRAINING, CREDENTIALING AND PRIVILEGING OF ASSISTANT MEDICAL OFFICER IN CARDIOLOGY KKM**

This well being developed logbook divided into three section A, B & C:

- Section A: Non-Invasive Cardiac Laboratory procedures
- Section B: Invasive Cardiac Laboratory Procedures
- Section C: Cardiac Rhythm Management & Electrophysiology Study

All Practical / Hands-on training must be document in this logbook and Local Supervisor will make an evaluation at the end of each procedure. Minimum requirement for each procedure state as below:

**SECTION A: Non-Invasive Cardiac Laboratory (NICL)**

| PROCEDURES | Required | | | Done | | |
|---|---|---|---|---|---|---|
| | O | A | P | O | A | P |
| Transthoracic Echocardiogram (TTE) | 50 | 50 | 100 | | | |
| Treadmill Exercise Stress Test (EST) | 25 | 25 | 50 | | | |
| 24 Hours Holter Monitoring | 25 | 25 | 50 | | | |
| Stress Echocardiogram (Pharmacological/ Exercise) | 5 | 5 | 10 | | | |

Comments By Head Of Department/Cardiologist:

_____

_____

_____

Signature of Assessor :

…….

Name / Stamp)

Date :

Verified by Head Of Department/ Cardiologist

……

(Name / Stamp)

Date :

**SECTION B : Invasive Cath. Laboratory ( ICL)**

- This section including of Haemodynamic monitoring & assisting cardiologist in related procedures

| PROCEDURES | Required | | | Done | | |
|---|---|---|---|---|---|---|
| | O | A | P | O | A | P |
| Haemodynamic Monitoring (Coronary Angiogram) | 25 | 25 | 100 | | | |
| Haemodynamic Monitoring (Percutaneous Coronary Intervention) | 25 | 25 | 100 | | | |
| Haemodynamic Monitoring (Right Heart Catheterization) | 5 | 5 | 10 | | | |
| Intra-Aortic Balloon Pump (IABP) | 5 | 5 | 10 | | | |
| Intravascular Ultrasound (IVUS) | 5 | 5 | 10 | | | |
| Fractional Flow Reverse (FFR/IFR) | 5 | 5 | 10 | | | |

Comments By Head Of Department/Cardiologist:

Signature of Assessor :

……

(Name / Stamp)

Date :

Verified by Head Of Department/ Cardiologist

……

(Name / Stamp)

Date:

**SECTION C: Cardiac Rhythm Management & Electrophysiology Study**

| PROCEDURES | Required | | | Done | | |
|---|---|---|---|---|---|---|
| | O | A | P | O | A | P |
| Cardiac Rhythm Management/ Cardiac Pacing | 25 | 25 | 50 | | | |
| Conducting the follow-up clinic for interrogation, programming and reprogramming of the implantable devices | 25 | 25 | 50 | | | |
| Electrophysiology Study (EPS) | 5 | 5 | 10 | | | |
| Radiofrequency Ablation (RFA) | 5 | 5 | 10 | | | |
| Cryo Ablation | 5 | 5 | 10 | | | |

Comments By Head Of Department/ Cardiologist:

Signature of Assessor :

Verified by Head Of Department/ Cardiologist

…….

Name / Stamp)

Date :

……

(Name / Stamp)

Date: