SENARAI SEMAK PERMOHONAN PEMBAHARUAN SIJIL (*RE-CREDENTIALING*) *ENDOSCOPY* BAGI PROFESION PENOLONG PEGAWAI PERUBATAN DAN JURURAWAT

Sila tandakan √ jika berkenaan dalam kotak yang disediakan:

Bil.	Maklumat	Tandakan √
1.	Borang permohonan baru ***APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE*** ***Rcred 1- (2018)*** diisi dengan lengkap oleh pemohon dan mesti mendapatkan sokongan serta ditandatangan oleh:- a. **Hospital berpakar** : Ketua Jabatan b. **Hospital tanpa pakar** : Pakar Perunding Lawatan Klinikal	☐
2.	Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	2.1 Perakuan Pendaftaran Tahunan *Annual Practising Certificate (APC)* Jururawat - (APC tahun terkini).*	☐
	2.2 Sijil *Credentialing* yang bakal tamat tempoh. 2.3 Sijil Pos Basik Gastrointestinal Assistant (Endoscopy)	☐ ☐

Nota : *Borang permohonan bagi Memperbaharui Sijil Credentialing mesti dipohon dan dihantar 6 (enam) bulan sebelum tarikh tamat tempoh Sijil Credentialing.
*****Sijil Credentialing tamat tempoh melebihi 1 tahun perlu membuat permohonan baru.***

Borang Permohonan *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, PRESINT 1
PUSAT PENTADBIRAN KERAJAAN PUTRAJAYA
625920 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, PRESINT 1
PUSAT PENTADBIRAN KERAJAAN PUTRAJAYA
625920 PUTRAJAYA

Tel : 03 8883 3543/3544
Faks : 03 8890 4149

Disemak oleh : .....
(Cop Nama Penyelia)

No Telefon Penyelia : .....

APPLICATION FOR RENEWAL OF CREDENTIALING CERTIFICATE

Name of Hospital : ……

Name of Applicant : ……

Identity Card No : ……

Position : ……

Tel. Number : Office : .....
Mobile : .....

Email Address : ……

Area of re-credentialing applied for (*tick in the appropriate box*) :

[ ] Perioperative
[ ] Ophthalmology
[ ] Emergency Medicine & Trauma Services
[ ] Intensive Care Nursing
[ ] Dialysis Care :
  [ ] Haemodialysis
  [ ] Peritoneal Dialysis
[ ] Anaesthesiology & Intensive Care Services
  [ ] Anaesthesia
  [ ] Peri-anaesthesia
  [ ] Intensive Care
[ ] General Pediatrics Nursing
[ ] Neonatal Nursing
[ ] Pre Hospital Care Services
[ ] Orthopedic Services
[ ] **Endoscopy Services**
[ ] Peri-Anaesthesia Care (P.A.C)
[ ] Cardiovascular Perfusion
[ ] Diagnostic Radiography
[ ] Radiation Therapy
[ ] Occupational Therapy
[ ] Physiotherapy
[ ] Dental Technology
[ ] Optometry
[ ] Dietetic
[ ] Speech Language Therapy
[ ] Audiology

Presently Credentialed from …….……..... till .....…….....

Present Credentialing Certificate No : ……..

Current *APC* No : ……

PLACE OF WORK SINCE OBTAINING CREDENTIALING CERTIFICATE

Please use additional sheets for extra space

Hospital	Place of work	Duration (From – Till)

DECLARATION

I request to renew my credentialing certificate in the above area for a period of 3 years.
I hereby declare the information given is correct.

Date: …… Applicant's Signature.....

RECOMMENDATION BY HEAD OF DEPARTMENT/ VISITING CLINICAL SPECIALIST

I certify that the above information is correct and this application is:

[ ] recommended

[ ] not recommended.

…….....……..... Date : ……

Signature

Official stamp :

DECISION OF SPECIALTY SUB-COMMITTEE (SSC)

This application is [ ] Approved [ ] Deferred* [ ] Rejected*

*Reasons: …….

……

……

Signature …… Date ……..

The above decision will be forwarded to the National Credentialing Committee (NCC) meeting for endorsement.