SENARAI SEMAK PERMOHONAN BAHARU (CREDENTIALING) *NEONATAL NURSING*

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:- **a. Hospital berpakar**: Ketua Jabatan Pediatrik **b. Hospital tanpa pakar**: Pakar Lawatan Klinikal Jabatan Pediatrik	☐
2.	Ringkasan buku log yang ditandatangan oleh *assessor* dan disahkan oleh:- a. **Hospital berpakar**: Ketua Jabatan Pediatrik b. **Hospital tanpa pakar**: Pakar Lawatan Klinikal Jabatan Pediatrik	☐
3.	Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	3.1 Perakuan Pendaftaran Sebagai Jururawat	☐
	3.2 Perakuan Pendaftaran Tahunan *Annual Practising Certificate* (APC) Jururawat - (APC tahun terkini).*	☐
	3.3 Sijil Neonatal Resuscitation Program	☐
	3.4 Sijil Pos Basik Perawatan Neonatologi	☐
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 :

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

Di semak oleh :.....
(Cop Nama Penyelia)

No Telefon Penyelia : ……

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: …….
(example: Lembaga Jururawat Malaysia, Lembaga Pembantu Perubatan Malaysia, Majlis Optik Malaysia)

Date of Full Registration with respective professional Board / Council: ……..

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 :-
[ ] Anaesthesia
[ ] Peri-anaesthesia
[ ] Intensive Care
[ ] General Paediatric Nursing
[ ] **Neonatal Nursing**
[ ] Orthopaedic Services
[ ] Endoscopy Services
[ ] Peri-Anaesthesia Care (P.A.C)
[ ] General Paediatric Nursing
[ ] Cardiovascular Perfusion
[ ] Pre Hospital Care Services
[ ] Physiotherapy
[ ] Occupational Therapy
[ ] Diagnostic Radiography
[ ] Radiation Therapy
[ ] Dental Technology
[ ] Speech Language Therapy
[ ] Dietetic
[ ] Audiology

6.1 Credentialling applied for : [ ] Core Procedures

[ ] Specialised Procedures in
a)……..
b)……..
c)……..

[ ] Optional Procedures
a) ……..
b) ……..
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 Pediatric Department)

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 Pediatric Department / Visiting Clinical Specialist)

….....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.

SUMMARY OF NURSES PROGRESS CLINICAL PRACTICE RECORD
(CORE PROCEDURES)

NAME:
I/C NO:

No.	Procedures	Required	Done	Remarks
1.	Admission of newborn	10		
2.	Clinical assessment of neonate	10		
3.	Anthropometric measurements	10		
4.	Thermoregulation of newborn	10		
5.	Stabilization and transfer of neonate	3		
6.	Discharge of newborn	10		
7.	Application of pulse oximeter and interpretation of oxygen saturation	5		
8.	Setting up invasive blood pressure monitoring	2		
9.	Use of cardiorespiratory monitor and alarm limit setting	10		
10.	Heel prick	10		
11.	Incubator care (including disinfection)	5		
12.	Care of neonates in basic incubator	5		
13.	Care of neonates in humidified incubator	2		
14.	Weaning neonates from incubator	5		
15.	Use of radiant warmer – manual	5		
16.	Use of radiant warmer – servo-controlled	5		
17.	Phototherapy	10		
18.	Checking photo light irradiance	10		
19.	Administration of nasal prong oxygen	5		
20.	Setting up conventional ventilator	10		
21.	Care of baby on conventional ventilator	10		
22.	Setting up non-invasive ventilator	10		
23.	Care of baby on non-invasive ventilator	10		
24.	Blood gas interpretation	5		
25.	Assist in umbilical venous and arterial cannulation	5		
26.	Assist in peripherally inserted central catheter placement	5		
27.	Care of central line	10		
28.	Setting up total parental nutrition	10		
29.	Blood sampling from arterial line	5		

No.	Procedures	Required	Done	Remarks
30.	Education on collection and storage of expressed breast milk	10		
31.	Handling of expressed breast milk and formula milk	10		
32.	Cup/spoon feeding	10		
33.	Enteral tube feeding	10		
34.	Administration of medication	10		
35.	Monitoring of patient under sedation	10		
36.	Bag valve mask resuscitation	10		
37.	Suctioning – oro/nasopharyngeal	10		
38.	Assist in intubation	10		
39.	Endotracheal tube suction – open	10		
40.	Endotracheal tube suction – closed	6		
41.	Extubation of patient	10		
42.	Assist lumbar puncture	2		
43.	Blood transfusion	3		
44.	Prepare infant for retinopathy of prematurity screening	6		

COMMENTS :

_____

_____

_____

Signature of Assessor

……
(Name / Stamp)
Date :

Verified by Head of Department / Visiting Clinical Specialist

…….
(Name / Stamp)
Date :

SUMMARY OF NURSES PROGRESS CLINICAL PRACTICE RECORD

(OPTIONAL PROCEDURES)

No.	OPTIONAL PROCEDURES	Required	Done	Remarks
1.	Use of transcutaneous bilirubin meter	6		
2.	Use of transcutaneous carbon dioxide monitor	3		
3.	Setting up high frequency ventilator	6		
4.	Care of neonates on high frequency ventilation	6		
5.	Care of neonates on inhaled nitric oxide	3		
6.	Care of newborn undergoing hypothermia therapy	3		
7.	Stoma care	6		
8.	Care of patient with tracheostomy	3		
9.	Assist chest tube placement	3		
10.	Care of patient with chest tube	3		
11.	Newborn Hearing Screening	6		
12.	Preparation and assisting in exchange transfusion	2		
13.	Administration of oral sedation	3		
14.	Administration of medication by rectal route	2		

COMMENTS:

_____

_____

_____

Signature of Assessor

……

(Name / Stamp)
Date :

Verified by Head of Department /
Visiting Clinical Specialist

…….

(Name / Stamp)
Date: