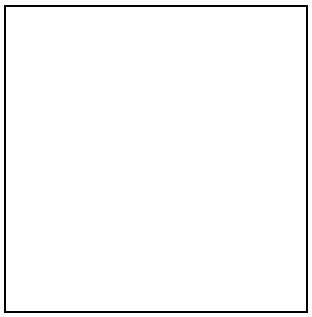
APPLICATION FOR LETTER OF CREDENTIALING AND PRIVILEGING (CHAPTER 3)

1. PERSONAL DETAILS



Full Name : _____

NRIC / Passport No. : _____

Malaysian Medical Council Reg. No. : _____

Current Annual Practicing Certificate No. /Year : _____

Clinic/Hospital Name : _____

_____

_____

Home Address : _____

_____

Telephone No. :Office:_____Residence:_____Mobile: _____

Fax No. : _____

Email Address : _____

2. PERSONAL QUALIFICATION / TRAINING

2.1 Basic Qualification:

Qualification : _____

University/Awarding body : _____

Date of Qualification : _____

2.2 Post Graduate Qualifications: (If applicable)

Qualification : _____

University/Awarding body : _____

Date of qualification : _____

Years of aesthetic medical practice experience (part time/full time); _____

2.3 Work Experience

PERIOD	PLACE OF PRACTICE	POSITION

2.4 Information on Professional Indemnity

Name of insurance provider : _____

Type of insurance : _____

Start date of insurance :_____

Period of insurance : _____

***Note*: Upon approval of the Letter of Credentialing & Privileging, medical practitioners performing aesthetic medical practice should have appropriate professional indemnity.**

3. DECLARATION TO PERFORM AESTHETIC MEDICAL PROCEDURES

Please attach with this application form, a copy of the certificate obtained (overseas or local training), details of training courses, organizers, trainer(s)' name and CV if necessary, details of hands-on experience, duration of course and examinations / tests.

Scope of Practice and Requirements for Surgical Specialists:
Surgical Modalities

Type of Treatment and Procedure	Tick	No. of Procedures Performed	Name of Trainers/Supervisors	Title of Certificate Obtained
Abdominoplasty				
Blepharoplasty-Upper eyelid Lower Eyelid				
Breast Implant				
Breast enhancement (other than implant)				
Breast reduction				
Brow Lift				
Fat Grafting				
Type of Treatment and Procedure	**Tick**	**No. of Procedures Performed**	**Name of Trainers/Supervisors**	**Title of Certificate Obtained**
Hair Transplant				
Implant - Face				
Implant – Nose				
Lasers, Ablative (Including fractional & resurfacing)				
Liposuction (LA & < 1 Litre aspirate) Liposuction (GA/ >1 Litre)				
Rhinoplasty				
Rhytidectomy				

Facelift				
Mini Lift				
Thread Lift				
Phlebectomy				

Note :

This list is subject to review.

Scope of Practice and Requirements for Surgical Specialists:
Non-Surgical Modalities

Type of Treatment and Procedure	Tick	No. of Procedures Performed	Name of Trainers/Supervisors	Title of Certificate Obtained
NON INVASIVE				
Chemical peel (Superficial)				
Microdermabrasion				
Intense pulsed light (IPL)				
MINIMALLY INVASIVE				
Chemical peel (Medium depth)				
Botulinum toxin injection				
Filler injection-excluding silicone and fat				
Superficial Sclerotherapy				
Lasers for treating skin pigmentation				
Lasers for skin rejuvenation (including fractional ablative)				
Lasers for hair removal (e.g long pulse Nd:YAG, Diode)				
Skin tightening procedures – radio frequency, ultrasound, infrared up to upper dermis				
INVASIVE				
Lasers for treating vascular lesions				
Chemicals peels (Deep)				
Radiofrequency (External application)				
Ultrasound device (External application)				

Note :

This list is subject to review.

Additional Information on Training (if any)

Title of Certificate Obtained	Year Obtained	Name of Organiser	Details of Hands on Experience	Name(s) of supervisors/ Trainers	Duration	Details of any Examinations / Tests

4. NAME OF REFEREES

Please list at least two referees familiar with your clinical skills

REFEREE 1

Name : _____

IC / Passport No. : _____

Designation : _____

MMC No. : _____

APC No. : _____

LCP No. (if any) : _____

Telephone No. : Office: _____ Residence: _____Mobile:_____

Fax No. : _____

Postal Address : _____

_____

Email Address : _____

Referee's Signature **:** _____

REFEREE 2

Name : _____

IC / Passport No. : _____

Designation : _____

MMC No. : _____

APC No. : _____

LCP No. (if any) : _____

Telephone No. : Office : _____ Residence: _____Mobile: _____

Fax No. : _____

Postal Address : _____

_____

Email Address : _____

Referee's Signature : _____

5. DECLARATION

I declare that the information provided in this application form is true and authentic and herein remains unchanged to-date. To the best of my knowledge and belief, I have not withheld any material fact. I understand that my practice may be audited. I also note that I may be required to submit additional details for further assessment / review.

_____ _____

Name of Medical Practitioner Date

_____

Signature

Please submit your application form and supporting documents to:

CSAMM-MAPACS Joint Committee for Aesthetic Medical/Surgical Practice,
G-1 Medical Academies of Malaysia,
210 Jalan Tun Razak,
50400 Kuala Lumpur.

Email: acadmed@po.jaring.my
Tel : 03-40234700/40254700/40253700
Fax : 03-40238100

6. FOR OFFICE USE ONLY

6.1 Evidence of adequate training

Please tick the appropriate box Yes ☐ No ☐

6.2 Recommendation for procedures requested

List of procedures	Recommendation		Remarks
	Yes	No	

6.3 Comments/suggestions:

_____

_____

_____

_____

_____

_____ _____

Chairman
Joint Committee for
Aesthetic Medical/Surgical Practice
( )

Member
Joint Committee for
Aesthetic Medical/Surgical Practice
( )

_____ _____

Date Date