APPLICATION FOR CLINICAL PRIVILEGES
EAST PAHANG CLUSTER HOSPITAL

☐ HTAA ☐ H.PEKAN ☐ H.ROMPIN ☐ HMS

YEAR: _____

1. Personal Details

(For Office Use Only)

Full Name :_____

I/C Num. :_____

Home Address:_____

Telephone :_____ (Mobile)

Department / Unit / Area:_____

Date of Reporting in Current Department / Unit / Area:_____

Staff Position:

- ☐ Nurse
- ☐ Assistant Medical Officer
- ☐ Pharmacist
- ☐ Allied Health Professionals (AHP)

Please state:_____

Grade of Position:_____

Date of Appointment to MOH:_____

Duration of service:_____ year(s)

[(✓) where relevant]

Evidence of qualification

Yes ☐
No ☐
Authenticated ☐

Yes ☐
No ☐
Authenticated ☐

2. Qualifications / Training

(For Office Use Only)

Yes ☐

No ☐

Authenticated ☐

2.1 Professional Qualifications

Diploma / Degree / Masters / etc	University / College	Year of Qualification

(Please attach certified copy of diploma / degree / masters certificate)

2.2 Post Basic Training (*Optional)

Type of Training	Institution	Duration (Months)	Year of Qualification

(Please attach certified copy of Post Basic Certification)

3. Working Experience (Start from Current Place of Work)

(For Office Use Only)

Yes ☐

No ☐

Authenticated ☐

Hospital / Institution	Department / Discipline	Date (Month & Year)	
		From	To

(Please attach separate list if insufficient space)

4. Professional Registration

4.1 Registered with:

_____

(Example: *Lembaga Jururawat Malaysia, Lembaga Pembantu Perubatan Malaysia, Lembaga Farmasi Malaysia, Majlis Optik Malaysia*, etc.)
(Please attach certified copy of Registration Certificate)

4.1.1 Date of Full Registration with Respective Professional Board / Council:

_____

4.2 Current Annual Practicing Certificate Number:

_____

(Please attach certified copy of Annual Practicing Certificate)

5. Credentialing & Privileging Applied

(For Office Use Only)

- ☐ Intensive Care Nursing
- ☐ Peri-Operative
- ☐ 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
- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Diagnostic Radiography
- ☐ Radiation Therapy
- ☐ Dental Technology
- ☐ Speech Language Therapy
- ☐ Dietetic
- ☐ Audiology
- ☐ Optometry
- ☐ Others

Please state:

Yes	☐
No	☐
Authenticated	☐

6. Request for Approval of Privileges

I certify that the information provided on this application is complete and accurate. I request approval for the Clinical Privileges indicated below for the period of **3 years** starting from **Year**: _____ (state current year)

I. Core Privileges: (State Discipline e.g. General Medicine / Optometry)

_____

(**Compulsory:** Please attach **Summary of Core Procedure** prepared by department / unit. Applicant must fulfil the minimum requirement set for each procedure)

II. Special Privileges: (State Subspecialty or Specialized Procedures if any)

_____

(Please attach **Summary of Specialized Procedure**. Applicant must fulfil the minimum requirement set for each procedure)

7. Previous Privileging

(For Office Use Only)

Have the privileges you are requesting been granted to you at your previous place of employment?

☐ Yes. Please Specify:_____

(List the Discipline & Hospital that Confer the Privilege)

[(✓) where relevant]

☐ No

*** If YES, please attach:**

- A copy of Credentialing and Privileging Certificate from previous institution / hospital

8. Additional Education / Certification / Training

Have completed additional education / certification / training in the past 2 years?

☐ Yes. Please specify on a separate sheet.

☐ No

* All applicants must attach copies or evidence of any qualifications, structured training and current registration detailed in the application form.
* Copies of evidences of qualifications or training should be authenticated.

9. Declaration

In the past, have you had voluntary or involuntary termination of medical staff appointment or voluntary limitation, reduction or loss of clinical privileges at another hospital?

☐ Yes. Please specify on a separate sheet.

☐ No

Have you had any problems with your health status, which might affect your ability to carry out your clinical privileges at this hospital?

☐ Yes. Please specify on a separate sheet. Please provide the name of your personal physician.

☐ No

10. Referees / Supervisors

(For Office Use Only)

	Name of Referees (At least 2 Referees)	**Position**	**Address** (State department / unit & practicing hospital)
1			
2			

11. Request for Privileging & Permission for Authorization

I request approval for the stated Clinical Privileges for a period of 3 years.

I authorize the National and East Pahang Cluster Hospital Credentialing & Privileging Committee to consult with all persons or places of employment or education center that may have information bearing on professional qualifications and competence to carry out the credentials I have requested.

I release from liability all those who provide information in good faith and without malice in response to such inquires.

Signature of Applicant:_____ Date: _____
(with stamp)

12. Applicant Appraisal

(For Office Use Only)

(All components must be filled by a referee / supervisor)

*For Hospital Pekan, Rompin & Muadzam Shah: to be filled by **any officer assigned by Hospital Director**

Name of Applicant:_____

Name of Referee:_____

Note for referee: Please provide information in relation to the scope, level of professional and clinical competence in areas in which procedures are requested

1. **How long have you known the applicant professionally?**

   _____

2. **State your relation to applicant?**

   _____

3. **Your recommendation is based on?** [(✓) where relevant]

   * May (✓) more than 1

   ☐ General impression

   ☐ Close personal observation

   ☐ Composite evaluation by supervisors

   ☐ Others (please state):_____

4. **Please state your impression in the following assessment of the applicant's ethical, communication and professional performance.** [(✓) where relevant]

	Good	Above Average	Average	Below Average	Poor
Cllinical Knowledge					
Clinical Skills					
Professional Clinical Judgement					
Sense of Clinical Responsibility					
Cooperativeness					
Communication with Colleagues & Superiors					
Ethical conduct					
Compliance with hospital rules & regulations					

5. Overall recommendation for procedures requested

(For Office Use Only)

5.1 All Core Procedures (Compulsory)

Procedures	Recommend Highly	Recommend Without Reservation	Recommend With Some Reservation	Do Not Recommend
All Core Procedures (Compulsory)				

[(✓) where relevant]

5.2 All Specialized Procedures (Optional for subspecialty / specialized procedures)

Procedures	Recommend Highly	Recommend Without Reservation	Recommend With Some Reservation	Do Not Recommend
All Specialized Procedures (Optional)				

[(✓) where relevant]

5.3 Any Particular Procedure With Different Recommendation Than Above

(Optional) (Please attach separate list if insufficient space)

(Please state the procedure below)	Recommend Highly	Recommend Without Reservation	Recommend With Some Reservation	Do Not Recommend
1.				
2.				
3.				

[(✓) where relevant]

Signature of Referee:_____ Date: _____
(with stamp)

13. Head of Department Verification

(For Office Use Only)

Request reviewed by peer / supervisor; competency of this applicant has been considered and the individual healthcare provider's declaration of health status has been confirmed. The full range of privileges requested including high risk procedures have been considered.

Evaluation of professional performance, judgement and clinical and / or technical skills in areas specified have been completed. Issues such as documented changes in the hospital, facility mission, failure to perform a sufficient number of procedures to maintain proficiency or failure to use privileges granted have been taken into consideration in the recommendation for the requested privileges.

As the Head of Department, **I have reviewed with the applicant the specific procedures and / or treatments that are being requested**. The individual is **entitled the requested privileges** based on available, relevant results of ongoing appraisals of clinical performance and practices.

Recommendation: Approve / Disapprove (if disapprove, state reason)

_____ _____

Signature of Head of Department (with stamp) **Date**

*For Hospital Pekan, Rompin & Muadzam Shah: to be verified by **Hospital Director**

14. Privileging Committee Decision

COMMITTEE DECISION:

Approve:_____ **Review**:_____ **Disapprove**:_____
(if disapprove, state reason)

_____ _____

CHAIRMAN **Date**
EAST PAHANG CLUSTER HOSPITAL
CREDENTIALING AND PRIVILEGING COMMITTEE

SENARAI SEMAK DOKUMEN ASAS PROSES PRIVILEGING

HOSPITAL KLUSTER PAHANG TIMUR

BAGI *ALLIED HEALTH PROFESSIONALS*

(PERMOHONAN BARU**)**

HOSPITAL :_____

JABATAN / UNIT :_____

NAMA PEGAWAI :_____

JAWATAN & GRED :_____

NO. TELEFON :_____

NO	JUMLAH SALINAN	JENIS DOKUMEN	SILA TANDA (✓)
1	1 SALINAN	**BORANG PERMOHONAN BARU** NO SIRI BORANG:	
2	1 SALINAN	**SIJIL ASAS ANGGOTA / SIJIL DIPLOMA**	
3	1 SALINAN (optional)	**SIJIL POST BASIC (SEKIRANYA ADA)** **SIJIL DEGREE (SEKIRANYA ADA)** **SIJIL MASTER (SEKIRANYA ADA)** **SIJIL PhD (SEKIRANYA ADA)**	
4	1 SALINAN	**SIJIL PENDAFTARAN LEMBAGA** (Contoh: Lembaga Jururawat Malaysia, Lembaga Pembantu Perubatan Malaysia, Lembaga Farmasi Malaysia, Majlis Optik Malaysia, etc.)	
5	1 SALINAN	**SIJIL AMALAN TAHUNAN (APC)** SILA SERTAKAN APC TAHUN SEMASA (WAJIB) DAN APC TAHUN BERIKUTNYA (SEKIRANYA TELAH ADA)	
6	1 SALINAN (optional)	**SIJIL KOMPETENSI (SEKIRANYA ADA)**	
7	1 SALINAN	**SUMMARY OF CORE PROCEDURE** PERLU DISAHKAN PENYELIA / KETUA JABATAN	
8	1 SALINAN	**LOGBOOK** PERLU DISAHKAN PENYELIA / KETUA JABATAN	