APPLICATION FOR RENEWAL OF 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. :_____

Telephone :_____ (Mobile)

Department / Unit / Area:_____

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

Date of Expiry Previous Credential:_____

Credentialing Certificate No.:_____

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)

2. Qualifications / Training

(For Office Use Only)

2.1 Professional Qualifications

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

Yes ☐

No ☐

Authenticated ☐

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

2.2 Post Basic Training (*Optional)

Type of Training	Institution	Duration (Months)	Year of Qualification

(For Office Use Only)

Yes ☐

No ☐

Authenticated ☐

(Please attach certified copy of Post Basic Certification)

3. Professional Registration

3.1 Registered with:

_____

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

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

_____

3.2 Current Annual Practicing Certificate Number:

Yes ☐

No ☐

Authenticated ☐

_____

(Please attach certified copy of Annual Practicing Certificate)

4. 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)

5. Declaration

(For Office Use Only)

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

[(✓) where relevant]

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

[(✓) where relevant]

6. Referees / Supervisors

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

7. 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)

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 RENEWAL** NO SIRI BORANG:	
2	1 SALINAN	**SIJIL PRIVILEGING YANG LALU**	
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	