SENARAI SEMAK PERMOHONAN PEMBAHARUAN SIJIL (*RE-CREDENTIALING*) *OPHTHALMOLOGY* 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 *Oftalmologi* b. **Hospital tanpa pakar** : Pakar Lawatan Klinikal Oftalmologi	☐
2.	Ringkasan buku log yang ditandatangan oleh assessor dan disahkan oleh:- a. **Hospital berpakar:** Ketua Jabatan Oftalmologi b. **Hospital tanpa pakar:** Pakar Lawatan Klinikal Oftalmologi	☐
3.	Salinan Sijil Perlu **Disahkan** Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	2.1 Perakuan Pendaftaran Tahunan *Annual Practising Certificate (APC)* Jururawat / Penolong Pegawai Perubatan - (APC tahun terkini).*	☐
	2.2 Sijil *Credentialing* yang bakal tamat tempoh. 2.3 Sijil Pos Basik Perawatan Oftalmologi	☐ ☐

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 OPHTHALMOLOGY / 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.

SUMMARY OF OPHTHALMIC CLINICAL PROCEDURES
CLINICAL PRACTICE RECORD

Name:_____

Hospital: _____ Date:_____

No.	Procedure	No Of Procedures Performed (Minimum Number)	Number of Procedures Performed (Done)	Supervisor Comments
1.	Triaging	30		
2.	Measurement of Visual Acuity(Adult)	5		
3.	Measurement of Visual Acuity (Children)	5		
4.	Measurement of near vision	5		
5.	Eye Examination (Anterior segment)	5		
6.	IOP measurement and calibration using Tonopen	10		
7.	Pre-operative counselling	10		
8.	Perform Schirmer's test	4		
9.	Color vision testing – ishihara	5		
10.	Eyelid hygiene (Eye lid scrub	5		
11.	Eye dressing (First dressing)	10		
12.	Instilling eye drop with punctal (Occlusion)	10		
13.	Application of eye pad and eye Shield	10		
14.	Insertion and removal of bandage contact lens	2		
15.	Counseling on contact lens wear	2		
16.	Insertion and removal of eye Prosthesis	2		
17.	Perform eye rodding	2		
18.	Perform pH testing of tears	5		
19.	Perform eye irrigation	2		
20.	Perform corneal staining	5		
21.	Perform fundus photography	20		
22.	Perform conjunctival swab	2		
23.	Prepare and assist in corneal scrapping	2		
24.	Preparation and assist in ROP screening	5		
25.	Prepare and assist in laser therapy	5		
26.	Prepare and assist in FFA (if service available)	5		
27.	Prepare and assist in syringing of lacrimal drainage system	2		
28.	Prepare and assist in incision and Curettage (if service available)	2		
29.	Prepare and assist in intravitreal injection (If service available)	10		

COMMENTS :

_____

_____

Signature of Assessor

……

(Name / Stamp)

Date :

Verified by Head of Ophthalmology Department / Visiting Clinical Specialist

…….

(Name / Stamp)

Date:

SUMMARY OF OPHTHALMIC SURGICAL PROCEDURES
CLINICAL PRACTICE RECORD

Name:_____

Hospital: _____ Date:_____

No.	Procedure	No Of Procedures Performed (Minimum Number)	Number of Procedures Performed (Done)	Supervisor Comments
1.	Cleaning and sterilization of microsurgical instruments	20		
2.	Prepare and assist in ECCE	5		
3.	Prepare and assist in Phacoemulsification	20		
4.	Prepare and assist in pterygium excision	5		
5.	Prepare and assist in vitreoretinal surgery (If service available)	3		
6.	Preparation of intraocular gases for tamponade (If service available)	3		
7.	Prepare and assist in Trabeculectomy / GDD surgery (If service available)	1		
8.	Prepare and assist in corneal Transplantation	1		
9.	Prepare and assist in oculoplastic surgery (If service available)	1		
10.	Prepare and assist in squint surgery (If service available)	1		

COMMENTS :

_____

_____

Signature of Assessor

……
(Name / Stamp)
Date :

Verified by Head of Ophthalmology Department / Visiting Clinical Specialist

……
(Name / Stamp)
Date: