

SENARAI SEMAK PERMOHONAN BAHARU (*CREDENTIALING*) PERIOPERATIF BAGI PROFESION PENOLONG PEGAWAI PERUBATAN DAN JURURAWAT

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 ditandatangani oleh:- a. Hospital berpakar: Ketua Jabatan b. Hospital tanpa pakar: Pakar Lawatan Klinikal	☐
2.	Ringkasan buku log yang ditandatangani oleh assessor dan disahkan oleh:- a. Hospital berpakar: Ketua Jabatan b. Hospital tanpa pakar: Pakar Lawatan Klinikal Pembedahan	☐
3.	Salinan Sijil Perlu Disahkan Oleh Pegawai Pengurusan & Profesional (U41 ke atas):-	
	3.1 Perakuan Pendaftaran Sebagai Penolong Pegawai Perubatan / Jururawat	☐
	3.2 Perakuan Pendaftaran Tahunan <i>Annual Practising Certificate</i> (APC) Penolong Pegawai Perubatan / Jururawat - (APC tahun terkini).*	☐
	3.3 Sijil Pos Basik Perawatan Perioperatif	☐
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 :

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

Di semak oleh :
 (Cop Nama Penyelia)
 No Telefon Penyelia :

APPLICATION FOR CREDENTIALING

HOSPITAL: _____

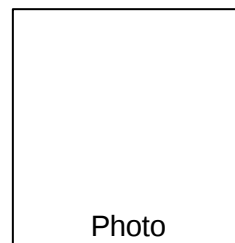
DATE OF APPLICATION: _____

1. PERSONAL DETAILS

Name:

Identification Card Number:

Area/ Discipline/ Specialty:



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 Operative 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 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

Signature

Date.....

The above decision will be brought to the next NCC meeting for endorsement.

SUMMARY OF LOG BOOK FOR PERIOPERATIVE

NAME:

I/C NO:

NO	CORE PROCEDURE	REQUIRED			DONE			REMARKS
		0	A	P	0	A	P	
1.	Assessment of patient on arrival to Operating Theater	2	5	8				
2.	Preparation for General Anaesthesia	3	4	8				
3.	Assist during Induction of General Anaesthesia	3	4	8				
4.	Preparation for Regional Anaesthesia	3	4	5				
5.	Assist during Regional Anaesthesia	3	5	5				
6.	Handling of Electro Surgical Unit	3	5	5				
7.	Care of patient in with Tourniquet	2	2	4				
8.	Care of patient in Supine Position	2	4	5				
9.	Care of patient in Lateral/ Kidney Position	2	2	5				
10.	Care of patient Lithotomy Position	2	5	5				
11.	Care of patient in Prone Position	2	5	5				
12.	Care of Patient in Orthopedic Extension Position	2	5	5				
13.	Care of patient in Trendelenburg Position	1	2	4				
14.	Surgical scrub. Gowning & Gloving	3	5	8				
15.	Circulating Nurse in General Surgery	3	5	8				
16.	Instrument Nurse in General Surgery	3	4	8				
17.	Circulating Nurse in Gynecology Surgery	3	5	8				
18.	Instrument Nurse in Gynecology Surgery	3	4	8				
19.	Circulating Nurse in Obstetric Surgery	3	5	5				
20.	Instrument Nurse in Obstetric Surgery	3	4	8				
21.	Circulating Nurse in Orthopedic Surgery	3	5	8				
22.	Instrument Nurse in Orthopedic Surgery	3	5	8				
23.	Circulating Nurse in Neurosurgery	2	5	4				
24.	Circulating Nurse in Otorhinolaryngology Surgery	2	3	4				
25.	Instrument Nurse in Otorhinolaryngology Surgery	2	3	4				
26.	Circulating Nurse in Plastic & Reconstructive Surgery	2	3	4				
27.	Instrument Nurse in Plastic & Reconstructive Surgery	2	2	4				
28.	Circulating Nurse in Urology Surgery	2	5	5				
29.	Instrument Nurse in Urology Surgery	2	5	5				
30.	Circulating Nurse in Ophthalmic Surgery	2	2	4				
31.	Care of Post Anaesthetic patient	2	5	8				
32.	Sterilization – Steam Under Pressure	2	5	5				
33.	Sterilization – Chemical Active Gluteraldehyde High Level Disinfection	2	5	5				

NO	CORE PROCEDURE	REQUIRED			DONE			REMARKS
		0	A	P	0	A	P	
34.	Sterilization – Monitoring of sterilizer	2	5	5				
35.	Cleaning, washing and packing of instrument for sterilization	2	5	5				
36.	Decontamination of environment	2	4	4				
37.	Decontamination of spillage	2	4	4				
38.	Decontamination of clinical waste	2	4	4				
39.	Decontamination of instrument & equipment	2	5	5				
40.	Handling of use drapes	2	2	2				
41.	Decontamination Of Electrical & Pneumatic Instruments	2	4	4				
42.	Clean And Care Of Fibre Optic Scopes	2	4	4				
43.	Handling Of Specimens							

COMMENTS :

Signature of Assessor

Verified by Head of Department /
Visiting Clinical Specialist

.....
(Name / Stamp)
Date :

.....
(Name / Stamp)
Date:

SUMMARY OF PROGRESS CLINICAL PRACTICE RECORD FOR PERIOPERATIVE CARE

NO.	OPTIONAL PROCEDURES	REQUIRED			DONE			REMARKS
		O	A	P	O	A	P	
1.	Instrument Nurse In Neuro Surgery	2	2	4				
2.	Instrument Nurse In Ophthalmic Surgery	2	4	4				
3.	Circulating Nurse In Vascular Surgery	2	0	4				
4.	Instrument Nurse In Vascular Surgery	2	2	4				

COMMENTS :

Signature of Assessor

Verified by Head of Department/
Visiting Clinical Specialist

.....
(Name / Stamp)
Date :

.....
(Name / Stamp)
Date: