gambar

MAKLUMAT PERIBADI PAKAR/PEGAWAI PERUBATAN
DI HOSPITAL-HOSPITAL
KEMENTERIAN KESIHATAN MALAYSIA

PROVIDER PROFILE

IC(New) :……

First Name :……

Last Name :……

Private Address :……

Postcode :……

City :……

State :……

Sex :……

Race :……

Date Of Birth :……

Age :……

Email :……

Phone(residence) :……

Cellular :……

Marital Status :……

Citizenship :……

Date Of Full Registration with MMC(date/m/year) :……..

Date Of Appointment into service(date/m/year) :……..

Number Of Full Registration :……..

Date Of last Promotion(date/m/year) :……..

Grade :……..

Spouse Name :……..

Occupation Of Spouse :……..

Office address Of Spouse :……..

:……..

:……..

CURRENT PLACEMENT

Department :……

Hospital / Institution :……

State :……

Types Of Service : **State Hospital** ☐

(Please tick where appropriate) **District Hospital with specialist** ☐

District Hospital without specialist ☐

Status Of Employment : **Permanent** ☐

(Please tick where appropriate) **Contract** ☐

Staff Position : **Senior Consultant** ☐

(Please tick where appropriate) **Consultant** ☐

Specialist ☐

Medical Officer ☐

BASIC MEDICAL TRAINING

Basic Degree

University/Medical School :……

Year Of Qualification :……

Housemanship

Place Of Housemanship Training :……

(If more than 1 hospital please list other training center)

Place	**Year**
1)……	**……**
2)……	**……**

Placement during Basic Medical Training

HOUSEMANSHIP

Discipline		**Place**	**Duration(month)**
Internal Medicine			
O&G			
Surgery			
Pediatric			
Orthopeadic			
Others(please list)			

MEDICAL OFFICER

Year :…….to…….

Discipline		**Place**	**Consultant**	**Duration(month)**
Internal Medicine				
O&G				
Surgery				
Pediatric				
Orthopeadic				
Others(please list)				

POST GRADUATE TRAINING

Specialist Training

Year Of Qualification :……

Qualification :……

Discipline :……

University /Awarding Body :……

Undergoing gazettment training:

Yes ☐

Completed ☐

If yes, date of commencement of training:……..

Date Of gazettment (date/m/year) **:……..**

Duration Of gazettment (month) **:……..**

Placement after completion of Specialist Training

Date (From….to…..) (d/m/year)	Hospital	Duration (months)

Fellowship Training(Subspecialty Training)
Are undergoing Training? ***:*****Yes / No**
If Yes,
Discipline :……
Date Of Commencement of training :……..
(date/m/year)
Training number, if applicable :……
Place and duration of training that you have undergone

Date (From….to…..) (d/m/year)	**Hospital**	**Name Of Trainer**	**Duration (months)**

Any overseas training :……

If Yes,

Area Of Training :……

Place Of Training :……

Trainer :……

Period Of Training :…….. to……..

(date/m/year)

If you have completed training ,

Certifying Body :……

Date Of Completion :……

(date/m/year)

Date Of gazettment for :……

subspecialty if applicable

(date/m/year)

Placement after completion of Fellowship Training

Date (From….to…..) (d/m/year)	Hospital	Duration (months)