

**NEW APPLICATION
FOR CLINICAL PRIVILEGES**

ALLIED HEALTH PROFESSIONALS, HOSPITAL TUANKU JA'AFAR SEREMBAN

Department of _____ Unit : _____

Personal Details				
Name:				
Specialty:				
Address:				
Telephone:	Residence:		Mobile:	

Current Professional Status

Professional Qualifications:

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

Other training:

Date of Full Registration (if applicable):

Date of Gazettement (if applicable):

Previous appointment (Hospital / Institutions)
 (list chronologically, attach separate list if insufficient space)

Year	Appointment	Hospital / Institutions

Continuing Education

(Educational meetings, seminar, courses etc attended during the past year. If more room is needed, list on a separate sheet)

Papers Published/ Presentations/ Special Interests

Registration

Are you currently registered to practice in Malaysia Yes No

If yes, quote registration number (APC)

Have you any physical or other condition which may limit your ability to practice your discipline

If yes, comment on a separate piece of paper Yes No

Request for Approval of Privileges

I request approval for the Clinical Privileges indicated below for the period of _____ to _____ (please indicate year). I certify that the information provided on this application is complete and accurate.

- a) Core Privileges (Broad area e.g. Medicine)

- b) Special Privileges (in area)

- c) Others e.g. Research

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

YES NO

If "YES" please specify or attached certificate :

Have completed additional education, certification or training in addition to CME in the past years?

YES NO

If "YES" please specify on separate sheet.

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

YES NO

If "YES" please give details on separate sheet.

Please list at least two referees familiar with your clinical skills.		
NAME	POSITION	ADDRESS

I authorize The Hospital Privileging Committee to consult with all persons or places of employment or education who may have information bearing on professional qualifications and competence to carry out the privileges I have requested. I release from the liability all those who provide information in good faith and without malice in response to such inquires.

Signature & Official Cop of Applicant:

_____ Date: _____

- Note:
1. First time applicants please attach copies or other evidence of any qualifications detailed in the application form.
 2. A separate typed curriculum vitae may be attached in support of this application.

APPLICATION FOR CLINICAL PRIVILEGES

NAME:

IDENTITY NO. : _____

I request privileges in:			
(see attached for specific privileges)			
a)	Core Privileges (Broad area e.g. Medicine)	
b)	Special Privileges (in area)	
c)	Others e.g. Research	
d)	Have the privileges you are requesting been granted to you at your previous place of employment?		
YES		NO	
If "YES" please specify			
e)	Have completed additional education, certification or training in addition to CME in the past two years?		
YES		NO	
If "YES" please specify on a separate sheet.			

I request approval for the Clinical Privileges indicated on the attached form.	
Signature & Cop of Applicant:	
_____	Date: _____

**APPLICATION FOR CLINICAL PRIVILEGES
(Head Of Department Recommendation)**

Our ref:
Date:

Hospital Privileging Committee
HTJS

This is to certify that _____ has been

employed as _____

As the HOD, this person is certified as competent and privileges to perform the procedure as stated below:

a) Core Privileges (Broad area e.g. Medicine)

b) Special Privileges (in area)

The education, training and / or experience identified, support this assertion of competence in privileges requested. This education, training and / or experience have been verified with the primary source, see attached.

Signature: _____

Date: _____

Official Cop : _____

Serial No: _____

Application status: Verified and complete Privileges approved from

_____ to _____
(dd / mm / yy) (dd / mm / yy)

Secretariat
Privileging AHP HTJS