RENEWAL APPLICATION
FOR CLINICAL PRIVILEGES

ALLIED HEALTH PROFESSIONALS, HOSPITAL TUANKU JA'AFAR, SEREMBAN

Department of _____ Unit: _____

Personal Details	
Name:	
Designation:	

Current Professional Status

Professional Qualifications:

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

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

Request for Approval of Privileges

I request approval for the renewal of Clinical Privileges indicated below. I certify that the information provided on this application is complete and accurate.
(Pl attached copy of previous Clinical Privileges 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 National Credentialing Committee and Hospital Sultanah Aminah, Johor Bahru 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 of Applicant:

_____ Date: _____

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 of Applicant:

_____ Date: _____

APPLICATION FOR CLINICAL PRIVILEGES
(Head Of Department Recommendation)

Our ref:
Date:

Chairman
Hospital Privileging Committee
HSAJB

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: _____

Serial No: _____

Application status: Verified and complete Privileges approved from

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

_____
Secretary HPC
HSAJB