

Hospital Tuanku Ja'afar Seremban

Kementerian Kesihatan Malaysia



HOSPITAL TUANKU JA'AFAR

BORANG PERMOHONAN - BARU

Urusetia
Privileging & Credentialing
Unit Kualiti

DOKUMEN YANG DIKEMUKAKAN UNTUK PERMOHONAN BARU

NAMA PEGAWAI :

GREED :

- | | |
|--|--------------------------|
| 1) Lampiran CP (<i>Perkara no.1 hingga no.9 lengkap</i>) | <input type="checkbox"/> |
| 2) Appendix CP1 | <input type="checkbox"/> |
| 3) Appendix CP1 A | <input type="checkbox"/> |
| 4) Appendix CP2 (<i>Perkara no.1 hingga no.10 lengkap</i>) | <input type="checkbox"/> |
| 5) Salinan Ijazah | <input type="checkbox"/> |
| 6) Salinan Ijazah Lanjutan (<i>Jika Ada</i>) | <input type="checkbox"/> |

Disahkan buku log telah dilengkapkan dan diluluskan oleh Ketua Jabatan

HOSPITAL TUANKU JA'AFAR SEREMBAN**CLINICAL PRIVILEGES**

1. Nama : _____
2. No. I/C : _____
3. Jawatan : _____
4. Majikan : **PENGARAH**
HOSPITAL TUANKU JA'AFAR SEREMBAN
5. 'Privileges Applied' : _____
6. 'Core Privileges' : _____
7. Tempoh Latihan : Dari _____ Hingga _____
(Diisi Oleh Pegawai)
8. Tempoh Kelulusan : Dari _____ Hingga _____
Di pohon

Disemak**Ya****Tidak****Diluluskan****Ya****Tidak****Modification to Above
Privileges****Ya****Tidak**_____
(Cop Ketua Jabatan)

Tarikh :

**APPLICATION
FOR CLINICAL PRIVILEGES**

HOSPITAL _____

Department _____

Personal Details

Name _____

Speciality _____

Private Address _____

Telephone _____

Residence _____

Mobile _____

Staff Position :

Consultant

Specialist

Clinical Specialist

Medical Officer

Nursing

Allied Health

Current Professional Status

Professional Qualifications:

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

Other training

Date of Full Registration _____

Date of Gazettement (Clinical Specialist) _____

Previous appointment (Hospitals / Institution)

(List chronologically, attach separate list if insufficient space)

CONTINUING EDUCATION (Educational meetings, Seminars, 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

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

If yes quote registration number

Yes No

Request for Approval of Privileges

I request approval for the Clinical Privileges indicated below for the period of _____ to _____ . (Please indicate date) 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 eg. Research

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

Yes No

If "YES" please specify

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

Yes No

If "YES" please specify on a separate sheet

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

Yes No

If "YES" please give details on a separate sheet

Please list at least two referees familiar with your clinical skills

NAME	POSITION	ADDRESS
<hr/>		
<hr/>		
<hr/>		

I authorise the National Credentialing Committee and hospital _____ 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 liability all those who provide information in good faith and without malice in response to such inquiries

Signature of Applicant _____ Date _____

Note

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

**APPLICATION
FOR CLINICAL PRIVILEGES**

NAME : _____

I request privileges in:
(see attached for specific privileges)

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

b) Special Privileges in (area)

c) Other eg 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 _____

Appendix CP2

APPLICANT APPRAISAL

NAME : _____

1. _____ has requested privileges in _____ . Please provide information relative to the scope and level of professional and clinical competence in the areas in which privileges are sought, health status and fulfillment of responsibility as a member of the medical staff.
2. How long have you known the applicant professionally and what is your relationship?

3. Staff category of applicant/Grade _____
4. Period for which applicant was granted medical privileges from _____ to _____
5. What specific privileges were granted? See attached requested privileges - you may use this form to specify

IF THE ANSWER IS YES TO ANY OF THE FOLLOWING QUESTIONS, PROVIDE DETAILS ON A SEPARATE SHEET.

6. Has this applicant ever been suspended, disciplined or has his/her privileges voluntarily or involuntarily restricted or not renewed? YES NO
7. To your knowledge, does this applicant have any existing health problems that could affect his/her medical practice? YES NO

Please provide the following information

8. The number and types of procedures performed by the applicant on record (attach separate sheet).

The skill and competence demonstrated in performing invasive procedures (include information on appropriateness, outcome and the number of procedures performed).

General Comments:

9. Please address the applicant's clinical judgment and technical skills as reflected in the results of quality assurance activities and peer review.

10. Please complete the following assessment of the applicant's ethical and professional qualifications. **Please tick (✓) at the appropriate box.**

	Average	Above Average	Below Average	No Knowledge
Clinical Knowledge				
Clinical Skills				
Professional Clinical Judgement				
Sense of clinical responsibility				
Ethical Conduct				
Co-operativeness, ability to work with others				
Documentation/Medical record timeliness & quality				
Teaching skills				
Compliance with hospital rules & regulations				

OVERALL RECOMMENDATION FOR PRIVILEGES REQUESTED

- _____ Recommend highly
- _____ Recommend without reservation
- _____ Recommend with some reservation
- _____ Do not recommend

RECOMMENDATION BASED ON : (May Choose More Than One)

- _____ Close personal observation
- _____ General impression
- _____ Composite of evaluation by supervisors
- _____ Other _____

PLEASE PROVIDE ADDITIONAL COMMENTS ON THIS APPLICANT WITHIN THE FRAMEWORK OF THE ATTACHED PRIVILEGES.

COMMENTS:

_____		_____	
Signature		Title	
_____		_____	_____
Name of Institution/Hospital		Phone Number	Date

DECISION:

REVIEWED: _____	APPROVED : _____
MODIFICATIONS TO ABOVE PRIVILEGES :	YES _____ NO _____
IF YES, PLEASE STATED _____	
_____ CHAIRMAN, HOSPITAL PRIVILEGING COMMITTEE	_____ DATE