BORANG PERMOHONAN- PEMBAHARUAN

Urusetia
Privileging & Credentialing
Unit Kualiti

DOKUMEN YANG DIKEMUKAKAN UNTUK PEMBAHARUAN

NAMA PEGAWAI : _____

GRED : _____

1) Lampiran CP (*Perkara no.1 hingga no.9 lengkap*) ☐

2) Appendix CP4 (*Perkara no.1 hingga no.6 lengkap*) ☐

3) Appendix CP5 ☐

4) Appendix CP6 (*Perkara no.1 hingga no.10 lengkap*) ☐

5) Appendix CP7 (*Perkara no.1 hingga no.8 lengkap*) ☐

LAMPIRAN CP

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.	**Tarikh sijil C&P sebelum ini**	**:**	Dari ..... Hingga .....
8.	**Tempoh Kelulusan Di pohon**	**:**	Dari ..... Hingga .....

Disemak	**Ya**	**Tidak**
Diluluskan	**Ya**	**Tidak**
Modification to Above Privileges	**Ya**	**Tidak**

_____

(Cop Ketua Jabatan)

Tarikh :.....

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Appendix CP4

PRIVILEGING CHECKLIST
REAPPRAISAL/REPRIVILEGING

APPLICANT'S NAME : _____

PLEASE SUBMIT THE FOLLOWING INFORMATION

1. Application for Renewal of Clinical Privileges _____

2. Reappraisal by Head of Department _____

3. Peer Recommendation (two required) _____

4. Current CV, if available _____

PRIMARY SOURCE DOCUMENTATION

5. Written verification of education/certification/training, since last privileging

_____

6. Written verification of past and concurrent professional employment (dates and indication that employee is in good standing) since last privileging within the last three years

_____

APPLICATION FOR RENEWAL OF CLINICAL PRIVILEGES

_____ **SERVICE**

HOSPITAL _____

SECTION A: Personal Details

Name _____

Service / Specialty _____

Department _____

Staff Position :

Consultant ☐ Clinical Specialist ☐ Specialist ☐

Medical Officer ☐ Nursing / Allied Health ☐

Request for approval of Privileges

Type of Request: ☐ Triennial Renewal

a) I request privileges in:
(See attached for specific privileges

_____

_____

_____

b) 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

SECTION B : Current Professional Status

The following information is offered in support of the request for renewal of clinical privileges. Please answer each question as it applies to the period of time since your last approval of privileges.

For any questions answered "YES", provide complete information on a separate sheet of paper and attach to this request.

Since your last Approval Of Privileges

Membership in professional organizations (Membership, Fellowship, Medical Society)

Current appointments in a teaching institution

Have you been granted privileges at any additional hospitals? If so list.

Please provide a listing of CME that support requested clinical privileges.
(Attach a separate sheet if necessary)

Please list at least two peers familiar with your clinical skills

NAME	POSITION	ADDRESS

Other information

(Include any additional information that you wish to bring to the attention of the Hospital Privileging Committee.)

Physical and Mental Health

Have you had any problems with your health status, which might affect your ability to carry out your clinical privileges at this hospital?

If yes, comment on a separate piece of paper

YES ☐ NO ☐

Have you been hospitalised in the last two years for anything that would interfere with your ability to carry out your duties?

YES ☐ NO ☐

Name of personal physician if you have answered " YES" to above. (Give address and phone number)

In the past have you had voluntary or involuntary suspension, limitation, reduction or loss of clinical privileges at another hospital, not renewed or voluntarily relinquished?

YES ☐ NO ☐

If "YES" please give details.

I request approval for the Clinical Privileges indicated on the form for the period of _____ to _____ (Please indicate date).

Signature of Applicant _____

Date _____

REQUEST REVIEWED BY PEER/PHYSICIAN; COMPETENCY OF THIS APPLICANT HAS BEEN CONSIDERED AND THE INDIVIDUAL HEALTHCARE PROVIDER'S DECLARATION OF HEALTH STATUS HAS BEEN CONFIRMED. THE FULL RANGE OF PRIVILEGES FOR HIGH RISK PROCEDURES. EVALUATION OF PROFESSIONAL PERFORMANCE, JUDGEMENT AND CLINICAL AND/OR TECHNICAL SKILLS IN AREAS SPECIFIED HAS BEEN COMPLETED. THE INDIVIDUAL IS ENTITLED TO RETAIN THE REQUIRED PRIVILEGES BASED ON AVAILABLE, RELEVANT RESULTS OF ONGOING APPRAISALS OF CLINICAL PERFORMANCE AND PRACTISES.

AS THE HEAD OF DEPARTMENT, I HAVE REVIEWED WITH THE APPLICANT THE SPECIFIC PROCEDURES AND/OR TREATMENTS THAT ARE BEING REQUESTED. ISSUES SUCH AS DOCUMENTED CHANGES IN THE HOSPITAL/ FACILITY MISSION FAILURE TO PERFORM A SUFFICIENT NUMBER OF OPERATIONS AND/OR PROCEDURES TO MAINTAIN PROFICIENCY, OR FAILURE TO USE PRIVILEGES PREVIOUSLY GRANTED HAVE BEEN TAKEN INTO CONSIDERATION IN THE RECOMMENDATION FOR RENEWAL OF PRIVILEGES.

NARRATIVE OR CURRENT PROFICIENCY ATTACHED.

RECOMMEND: APPROVAL/DISAPPROVAL (if disapproved, state reason.)

_____ _____

SIGNATURE OF HEAD OF DEPARTMENT DATE

DECISION:

REVIEWED: _____ APPROVED : _____

MODIFICATIONS TO ABOVE PRIVILEGES : YES _____ NO _____

IF YES, PLEASE STATED: _____

_____ _____

CHAIRMAN, DATE

HOSPITAL PRIVILEGING COMMITTE

REAPPRAISAL BY HEAD OF DEPARTMENT
FOR
RENEWAL OF CLINICAL PRIVILEGES

Hospital : _____

SPECIALIST'S NAME : _____
DEPARTMENT : _____
PERIOD COVERED : _____

ADDITIONAL INFORMATION REQUIRED FOR "NO" ANSWERS
Please tick (√) the appropriate box.

		YES	NO
1.	Have the individual' clinical and / or technical skills been observed and evaluated	☐	☐
2.	Does the individual exercise appropriate professional judgement and performance?	☐	☐
3.	Does the individual show positive evidence of contributions to patient care and quality assurance?	☐	☐
4.	Does the individual have an acceptable attitude towards patients, medical and other members of the Hospital Staff?	☐	☐
5.	Timely completion and preparation of medical and other required patient records.	☐	☐
6.	Does the individual actively participate in department and Hospital activities?	☐	☐
7.	Does the individual attend at least 60% or more of all scheduled department/committee meeting?	☐	☐
8.	Should the individual's requested clinical privileges be approved?	☐	☐
9.	Does the individual exercise ethical conduct?	☐	☐
10.	The individual is free of physical or mental disability or a change in health status, which would impact professional functioning?	☐	☐

SIGNATURE : _____ _____
Head of Department Date

Appendix CP7

PEER APPRAISAL OF MEDICAL STAFF MEMBER

Using the items listed below as guidelines, please provide your evaluation of Dr. _____ 's clinical practice at this hospital.

1.	Has exercised good clinical judgement in the care of patients in this hospital. **Comments :** _____	YES ☐	NO ☐
2.	Participates actively in Department activities. **Comments :** _____	YES ☐	NO ☐
3.	Has an acceptable attitude toward patients, medical staff and other members of the hospital. **Comments :** _____	YES ☐	NO ☐
4.	Has this applicant ever been suspended, disciplined or had his / her privileges voluntarily or involuntarily restricted or not renewed? **Comments :** _____	YES ☐	NO ☐
5.	To your knowledge does this applicant have any existing health problems that could affect his/her medical practice?	YES ☐	NO ☐

6. Please provide the following information:
   a. The skill and competence demonstrated in performing procedures (include information on appropriateness, outcome and the number of procedures performed). Give details on separate sheet.

_____

_____

_____

7. Please address the applicant's clinical judgement and technical skills as reflected in results of patients outcome and peer observations.

_____

_____

8. Please complete the following assessment of the applicant's moral, ethical and professional qualifications: **Please tick (√) the appropriate box**.

	Above Average	Average	Below Average
Current medical knowledge			
Professional clinical judgement			
Sense of Clinical responsibility			
Ethical conduct			
Clinical skills			
Cooperativeness, ability to work with others			
Medical record timeless & quality			
Teaching skills			
Physician-patient relationship			
Physician-physician understanding			
Compliance with hospital rules and regulations			

OVERALL RECOMMENDATION

_____ Recommend highly

_____ Recommend without reservation

_____ Recommend with some reservation

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 in evaluating him/her for the granting of privileges requested.

COMMENTS:

_____

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