



## APPLICATION FOR CLINICAL PRIVILEGES

### HOSPITAL TENGGU AMPUAN AFZAN

DEPARTMENT \_\_\_\_\_ YEAR \_\_\_\_\_

(For Office Use Only)

#### 1. Personal Details

Name \_\_\_\_\_

I/C No \_\_\_\_\_ Passport No \_\_\_\_\_

Speciality \_\_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_

Office Address \_\_\_\_\_

Telephone Office \_\_\_\_\_ Residence \_\_\_\_\_ Mobile \_\_\_\_\_

Staff Position: \_\_\_\_\_ Grade : \_\_\_\_\_

Senior Consultant  Consultant  Specialist  Medical Officer

Grade Of Position (if applicable): \_\_\_\_\_

Duration of service in the above staff position: \_\_\_\_\_

Date of appointment to MOH (if applicable): \_\_\_\_\_

#### 2. Personal Qualification / Training

##### 2.1 Basic Qualifications:

Qualification: \_\_\_\_\_

University/Awarding body: \_\_\_\_\_

Date of Qualification: \_\_\_\_\_

##### 2.2 Post Graduates Qualifications:

Qualification: \_\_\_\_\_

University/Awarding body: \_\_\_\_\_

Date of qualification: \_\_\_\_\_

Date of Completed Gazettement: \_\_\_\_\_

Duration of experience after qualified : \_\_\_\_\_

#### Evidence of qualification

Yes

No

Authenticated

Yes

No

Authenticated

2.3 Subspecialty Training:

Qualification: \_\_\_\_\_

Yes

University/Awarding body: \_\_\_\_\_

No

Date of completed training: \_\_\_\_\_

Authenticated

Date of Completed Gazettement: \_\_\_\_\_

Duration of experience after Subspecialty Training : \_\_\_\_\_

**(Please attach copies or other evidence of any qualifications detailed in the form)**

**3. Previous Appointment (Hospitals/ Institutions)**

(List chronologically, attach separate list if insufficient space)

Hospitals/Institutions	Department	Date	
		From	To

**4. Papers Published/Presentations/Special Interests within the last five years**

(Please list chronologically, attach separate lists if insufficient space)

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**5. Registration**

Date of Full Registration with Malaysian Medical Council (if applicable) \_\_\_\_\_

Full Registration Number with Malaysian Medical Council \_\_\_\_\_

Are you currently registered to practice in Malaysia Yes  No

(If yes, please attach 2 current copies annual practicing certificate)

Evidence of APC

Yes

No

Authenticated

**6. 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

\_\_\_\_\_

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 two 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 limitation, reduction or loss of clinical privileges at another hospital.**

YES  NO

If "YES" Please specify on a separate sheet.

**7. Please list at least two referees familiar with your clinical skills.**

NAME	POSITION	ADDRESS

I authorize the National Credentialing Committee and Hospital \_\_\_\_\_ to consult with all persons or places of employment or education that may have information bearing on professional qualifications and competence to carry out the credentials 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*

- All applicants must attach copies or other evidence of any qualifications, structured training, continuing education and current registration detailed in the application form. Copies of evidences of qualifications, training and experience should be authenticated.*
- A separate typed curriculum vita may be attached in support of this application.*

Complete

Incomplete

# APPLICANT APPRAISAL

*Note For Referee:*

*Please provide information relative to the scope and level of professional and clinical competence in the areas in which procedures are requested.*

*Note for Applicant:*

*Please provide a completed copy of the "Application For Credentialing" to the referees. "Applicant Appraisal Forms" are to be sealed separately in an envelope and submitted together with the "Application For Credentialing."*

**NAME OF REFEREE:** \_\_\_\_\_

**NAME OF APPLICANT:** \_\_\_\_\_

**Has requested privileges in (area) \_\_\_\_\_  
for the following procedures:**

**1. LIST OF PROCEDURES REQUESTED:**

A) \_\_\_\_\_

B) \_\_\_\_\_

C) \_\_\_\_\_

D) \_\_\_\_\_

E) \_\_\_\_\_

(If more room is needed, please list on a separate sheet)

**2. How long have you known the applicant professionally and what is your relationship?**

\_\_\_\_\_

**3. The number and types of procedures performed by the applicant on record (copy of Section 8: Details of Procedures in the Application For Credentialing as attached)**

The skill and competence demonstrated in performing invasive procedures

(Include information on appropriateness, outcome and the number of

Procedures performed).

**General Comments:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. 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				

**OVERALL RECOMMENDATION FOR PROCEDURES REQUESTED**

Please complete the following recommendation for procedures requested

List of procedures	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
- \_\_\_\_\_ Others \_\_\_\_\_

Complete

Incomplete

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

*I request approval for the Clinical Privileges indicated on the form for the period of \_\_\_\_\_ to \_\_\_\_\_ (Please indicate date)*

*Signature of Applicant* \_\_\_\_\_

*Date* \_\_\_\_\_

**REQUEST REVIEWD 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 INDIVIDUALS IS ENTITLED TO RETAIN THE REQUIRED PRIVILEGES BASED ON AVAILABLE, RELEVANT RESULTS OF ONGOING APPRAISALS OF CLINICAL PERFORMANCE AND PRACTICES.**

**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 PERFORMED A SUFFICIENT NUMBER OF OPERATIONS AND/OR PROSEDURES 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 disapproval, state reason)**

\_\_\_\_\_  
**SIGNATURE OF HEAD OF DEPARTMENT**

\_\_\_\_\_  
**DATE**

**DECISION :**

**REVIEWED : \_\_\_\_\_ APPROVED : \_\_\_\_\_**

**MODIFICATIONS TO ABOVE PRIVILEGES : YES / NO**

\_\_\_\_\_  
**CHAIRMAN,  
HTAA PRIVILEGING COMMITTE**

\_\_\_\_\_  
**DATE**



**HOSPITAL TENGGU AMPUAN AFZAN**  
 Jalan Tanah Putih, 25000 Kuantan, Pahang Darul Makmur

## **LAPORAN PENILAIAN NARATIF**

**Nama Pegawai Dinilai:**

**No.KP / No.Pasport :**

Pegawai ini telah berkhidmat di jabatan/unit ..... sejak .....  
 Sepanjang perkhidmatan, beliau telah menunjukkan prestasi yang baik dalam menjalankan tanggungjawab yang diberikan. Beliau cekap dan berinisiatif untuk mempelajari perkara-perkara baru yang berkaitan dengan ..... Berdasarkan pengetahuan dan pengalaman yang diperolehi, beliau mampu serta berkebolehan dalam perawatan ..... sebagai pakar/pegawai perubatan ..... dengan jayanya.

Tandatangan : \_\_\_\_\_

Cop Ketua Jabatan : \_\_\_\_\_

Tarikh : \_\_\_\_\_





**HOSPITAL TENGGU AMPUAN AFZAN**  
Jalan Tanah Putih, 25000 Kuantan, Pahang Darul Makmur

**SURAT PENGESAHAN KETUA JABATAN**

**Adalah dengan ini disahkan bahawa**

**Nama :**

**No.KP / No.Pasport :**

**Telah berkelayakan untuk menjalankan tugas sebagai**

**Pakar / Pegawai Perubatan (Gred: \_\_\_\_\_)**

**Jabatan/Unit**

**Hospital Tengku Ampuan Afzan**

**Pengesahan ini dibuat berdasarkan kriteria-kriteria berikut :**

**Sijil Amalan Perubatan APC & MMC**

**Telah melalui latihan/kursus formal yang dianjurkan oleh jabatan/kementerian**

**Pengalaman kerja yang memuaskan**

**Laporan penilaian naratif penyelia**

.....  
( )

**Ketua Jabatan.....**  
**Hospital Tengku Ampuan Afzan**

**SENARAI SEMAK DOKUMEN ASAS PROSES PRIVILEGING  
HTAA KUANTAN  
PEGAWAI PERUBATAN/PAKAR**

NAMA				
JAWATAN/GRED				
JABATAN				
NO. TELEFON				
JENIS PERMOHONAN (SILA TANDA YANG BERKENAAN)		BARU		RENEWAL
<b>PERMOHONAN BARU</b>				
NO.	JUMLAH SALINAN	JENIS DOKUMEN		SILA TANDA
1.	1 salinan	Borang Permohonan Baru <b>HTAA-UK-B-057/pind.2002 CP1 (a)</b>		
2.	1 salinan	Resume lengkap & sekeping gambar berukuran pasport		
3.	1 salinan	Sijil MMC		
4.	1 salinan	Sijil amalan tahunan terkini (APC)		
5.	1 salinan	Sijil National Specialist Registry (Jika Ada)		
6.	1 salinan	Sijil degree & master		
7.	1 salinan	Laporan Penilaian Naratif Oleh Ketua Jabatan Yang Memantau <b>(HTAA-UK-B-061-LPN/CP)</b>		
8.	1 salinan	Surat Pengesahan Ketua Jabatan <b>(HTAA-UK-B-062-BP/CP)</b>		
9.	1 salinan	Buku Log <b>(Disahkan Ketua Jabatan)</b>		
10.	1 salinan	<i>Summary of core procedure (Disahkan Ketua Jabatan)</i>		
<b>PERMOHONAN RENEWAL</b>				
NO.	JUMLAH SALINAN	JENIS DOKUMEN		SILA TANDA
1.	1 salinan	Borang Permohonan Renewal <b>HTAA-UK-B-059/pind.2002 CP5</b>		
2.	1 salinan	Sekeping gambar berukuran pasport		
3.	1 salinan	Sijil MMC		
4.	1 salinan	Sijil amalan tahunan terkini (APC)		
5.	1 salinan	Sijil National Specialist Registry		
6.	1 salinan	Sijil Privileging yang lalu		
7.	1 salinan	Laporan Penilaian Naratif Oleh Ketua Jabatan Yang Memantau <b>(HTAA-UK-B-061-LPN/CP)</b>		
8.	1 salinan	Surat Pengesahan Ketua Jabatan <b>(HTAA-UK-B-062-BP/CP)</b>		
9.	1 salinan	Buku Log <b>(Disahkan Ketua Jabatan)</b>		
10.	1 salinan	<i>Summary of core procedure (Disahkan Ketua Jabatan)</i>		