



## APPLICATION FOR RENEWAL OF CLINICAL PRIVILEGES HOSPITAL TENGGU AMPUAN AFZAN

\_\_\_\_\_ SERVICE FOR YEAR \_\_\_\_\_

(For Office Use Only)

### SECTION A . Personal Details

Name \_\_\_\_\_

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

Service/Speciality \_\_\_\_\_

Department \_\_\_\_\_

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

Medical   
Assistant

Nurse

Allied   
Health

Date of expiry previous credential : \_\_\_\_\_ Credentialing Certificate No.: \_\_\_\_\_

### 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 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)

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Current appointments in a teaching institution

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

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

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**Please list at least two peers familiar with your clinical skills**

**NAME**

**POSITION**

**ADDRESS**

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**Please list at least two peers familiar with your clinical skills**

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

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**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 hospitalized 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)**

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**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?**

If "YES" Please give details.

YES

NO

*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 IDIVIDUAL HEALTHCARE PROVIDER'S DECLARATION OF HEALTH STATUS HAS BEEN COMFIRMED. 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 Jururawat /Pen.Peg.Perubatan/\* ..... dengan jayanya.

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

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

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

\*sila nyatakan bagi kategori Allied Health Profesional



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

## **SURAT PENGESAHAN KETUA JABATAN**

**Adalah dengan ini disahkan bahawa**

**Nama :**

**No.K/P / No.Pasport :**

**Telah berkelayakan untuk menjalankan tugas sebagai**

**Jururawat / Penolong Pegawai Perubatan/\*** \_\_\_\_\_  
(U54/U52/U48/U44 /U41/ U32 /U27/ U29 / U19 )

**Di**

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**Hospital Tengku Ampuan Afzan**

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

**Sijil Perawatan Pos Basik/Sijil Kemahiran Yang Berkaitan**

**Telah melalui latihan formal yang dianjurkan oleh jabatan**

**Pengalaman kerja yang memuaskan**

**Laporan penilaian naratif penyelia**

.....  
( )

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

\*sila nyatakan bagi kategori Allied Health

**SENARAI SEMAK DOKUMEN ASAS PROSES PRIVILEGING  
HTAA KUANTAN  
PARAMEDIK / ALLIED HEALTH**

<b>NAMA</b>				
<b>JAWATAN/GRED</b>				
<b>JABATAN</b>				
<b>NO.TELEFON</b>				
<b>JENIS PERMOHONAN (SILA TANDA YANG BERKENAAN)</b>		<b>BARU</b>		<b>PEMBAHARUAN</b>
<b>PERMOHONAN BARU</b>				
<b>NO.</b>	<b>JUMLAH SALINAN</b>	<b>JENIS DOKUMEN</b>		<b>SILA TANDA</b>
1.	1 salinan	Borang Permohonan Baru <b>HTAA-UK-B-058/pind.2022 AHP1(a)</b>		
2.	1 salinan	Sijil Asas Anggota		
3.	1 salinan	Sijil Pos Basik (jika berkaitan)		
4.	1 salinan	Sijil Amalan Tahunan yang terkini		
5.	1 salinan	Laporan Naratif oleh Ketua Jabatan / Pakar yang memantau <b>(HTAA-UK-B-061-LPN/CP)</b>		
6.	1 salinan	Surat Pengesahan Ketua Jabatan <b>(HTAA-UK-B-062-BP/CP)</b>		
7.	1 salinan	Buku Log		

<b>PERMOHONAN PEMBAHARUAN</b>				
<b>NO.</b>	<b>JUMLAH SALINAN</b>	<b>JENIS DOKUMEN</b>		<b>SILA TANDA</b>
1.	1 salinan	Borang Permohonan Renewal <b>HTAA-UK-B-060/pind.2022 AHP 5</b>		
2.	1 salinan	Sijil Privileging yang lalu		
3.	1 salinan	Sijil Amalan Tahunan yang terkini		
4.	1 salinan	Laporan Naratif oleh Ketua Jabatan / Pakar yang memantau <b>(HTAA-UK-B-061-LPN/CP)</b>		
5.	1 salinan	Surat Pengesahan Ketua Jabatan <b>(HTAA-UK-B-062-BP/CP)</b>		
6.	1 salinan	Buku Log		