APPLICATION FOR CREDENTIALING

CHECKLIST FOR SUBMISSION

The committee will only process your application if all the documents below are submitted. Please (√) in the box.

1.	**Curriculum Vitae**	☐
2.	**A copy of Current Annual Practising Certificate (APC)**	☐
3.	**A copy of Basic Degree**	☐
4.	**A copy of Postgraduate Qualifications**	☐
5.	**A copy of MOH Gazettement (if any)**	☐
6.	**Borang E.P.K. 2 – for a new specialist (*Perakuan Sebagai Pakar Klinikal*)**	☐

UNIVERSITI KEBANGSAAN MALAYSIA
National University of Malaysia

APPLICATION
FOR CLINICAL PRIVILEGES
UKM MEDICAL CENTRE

Department/ Unit : _____

Personal Details

UKM (PER) : _____ NRIC/Passport No : _____

Name : _____

Specialty : _____

Correspondence Address : _____

_____

_____

Tel No: ☐ Home: _____

☐ H/P : _____

Staff Position:

☐ Senior Consultant ☐ Consultant ☐ Specialist

☐ Medical Officer ☐ Allied Health

☐ Others (please state): _____

Current Professional Status

Professional Qualifications:

Bachelors Degree/Masters/ Fellowship/Diploma etc.	University/College etc.	Year of Qualification

Other Training :

Date of Gazettement (*Clinical Specialist*) : _____ (if available)

Previous Appointment (Hospitals/Institutions)
(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

☐ MMC Full Registration No : _____

☐ NSR Registration No : _____

Have you any physical or other condition which may limit your ability to practice your discipline *(If yes, comment on a separate piece of paper)*

☐ Yes ☐ No

Request for Approval of Privileges

I request approval of 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.

Core Privileges : _____
(*Broad area, e.g. Medicine*)
Special Privileges (*in area*) : _____
Other (*e.g. Research*) : _____

Have the privileges you are requesting been grated to you at 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?(*If YES, please specify on a separate sheet)*

☐ Yes ☐ No

In the past have you had voluntary or involuntary termination of medical staff appointment of voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital? (*If YES, please give details on a separate sheet)*

☐ Yes ☐ No

Please list at least two referees familiar with your clinical skills

Name	: _____	Name	: _____
Position	: _____	Position	: _____
Address	: _____	Address	: _____
	_____		_____
	_____		_____
Postcode	: _____	Postcode	: _____
City	: _____	City	: _____

I authorize the UKMMC Credentialing & Medical Privileges Committee 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.

I hereby certified all the above information is true.

Signature of Applicant	Date

Note:

1. *First time applicants please attach certified copies or other evidence of any qualifications detailed in the application form.*
2. *A separate typed curriculum vitae may be attached in support of this application.*
3. *Attach referees reports*

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APPLICANT APPRAISAL FOR CLINICAL PRIVILEGES
BY HEAD OF DEPARTMENT/ REFEREE

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 responsibilities as a member of the medical staff.

1. How long have you known the applicant professionally and what is your relationship to him/her?

   _____

2. Staff category of applicant/Grade _____
3. Period for which applicant has been previously granted medical privileges from _____ to _____
4. 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 ethnical and professional qualifications. **Please tick (√) at the appropriate box.**

	Average	Above Average	Below Average	No Knowledge
Clinical knowledge	☐	☐	☐	☐
Clinical skills	☐	☐	☐	☐
Professional Clinical judgment	☐	☐	☐	☐
Sense of clinical responsibility	☐	☐	☐	☐
Ethical conduct	☐	☐	☐	☐
Co-operative, ability to work with others	☐	☐	☐	☐
Documentation/Medical record timelines & 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:

I hereby certified all the above information is true.

Signature of Head of Department/
Referee

Date