**APPLICATION FOR RENEWAL OF CREDENTIALING & PRIVILEGING**

**HOSPITAL UiTM**

1. **P ERSONAL DETAILS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 | Name |  | | | |
| 2 | Address |  | | | |
| 3 | Telephone (Office) |  | | | |
| 4 | Telephone (Personal) |  | | | |
| 5 | E-mail address |  | | | |
| 6 | Staff Position | Consultant |  | Nurse |  |
| Specialist |  | Assistant Medical Officer |  |
| Medical Officer |  | AHP (please state) ………………………………………………….. |  |
| 7 | Department/Unit |  | | | |
| 8 | Date of expiry previous credential |  | | | |
| 9 | Credentialing Certificate No. |  | | | |

**B REQUEST FOR APPROVAL OF PPRIVILEGES**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 | Type of request | Triennial renewal | | |  |
| 2 | I request privileges in | Core procedures |  | Specific procedures |  |
| 3 | Please specify the privilege area  i. Core procedure – broad area  ii. Specific procedure – Subspecialty |  | | | |
| 4 | Have completed additional education, certification, or training in addition since the last privileging below; | Yes  (if Yes, please specify) |  | No |  |
|  | | | |
|  | | | |

**C 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 the period since your last approval of privileges.

For any questions answered **YES**, please provide complete information.

**Since your last approval of privileges;**

|  |  |  |
| --- | --- | --- |
| 1 | Membership in professional organization (Membership, Fellowship, Medical Society) |  |
| 2 | Current appointment in a teaching institution |  |
| 3 | Have you been granted privileges at any additional hospital? If so list. |  |
| 4 | Other information (include any additional information that you wish to bring to the attention of the C&P Committee) |  |

**D PLEASE LIST AT LEAST TWO PEERS FAMILIAR WITH YOUR CLINICAL SKILLS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | Name |  | | |
| Designation |  | | |
| Department/Unit |  | | |
| Institution |  | | |
| Phone contact |  | E-mail address |  |
| 2 | Name |  | | |
| Designation |  | | |
| Department/Unit |  | | |
| Institution |  | | |
| Phone contact |  | E-mail address |  |

**E PHYSICAL AND MENTAL HEALTH**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | 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 sheet. | | Yes |  | No |  |
| 2 | Have you been hospitalized in the last two years for anything that would interfere with your ability to carry out your duties? If YES, please provide details of physician involved in your treatment as below | | Yes |  | No |  |
| 3 | Name of Physician |  | | | | |
| Address |  | | | | |
| Contact No |  | | | | |

**F PAST CLINICAL PRIVILEGES HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | In the past have you had voluntary or involuntary suspension, limitation, reduction, or loss of clinical privileges, not renewed or voluntary relinquished? | | Yes |  | No |  |
| 2 | If YES, please give details |  | | | | |

I hereby certified all the above information is true.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Date

**REAPPRAISAL BY HEAD OF DEPARTMENT FOR**

**RENEWAL OF CLINICAL PRIVILEGES**

Department/Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICATION’S NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IDENTIFICATION CARD NUMBER : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AREA/DISCIPLINE/SPECIALTY : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERIOD COVER : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL INFORMATION REQUIRED FOR “NO” ANSWERS (**comment on a separate sheet)

**Please ( / ) in the appropriate box.**

**YES NO**

1. Have the individual’s clinical and / or technical skills been observed and evaluated?
2. Does the individual exercise appropriate professional judgement and performance?
3. Does the individuals show positive evidence of contributions to patient care and

quality assurance?

1. Does the individual have an acceptable attitude towards patients, healthcare personnel

and other members of the Hospital Staff?

1. Documentation / medical record timeliness and quality
2. Does the individual actively participate in department and Hospital activities?
3. Should the individual’s request for clinical privileges be approved?
4. Does the individual exercise ethical conduct?
5. Does the individual exercise has physical or mental disability or a change in health

status, which affect professional functioning?

**RECOMMENDATION BY HEAD OF DEPARTMENT**

As Head of Department, I have reviewed with the applicant the core/specialized procedures that are being requested.

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 | General comments |  | | | |
| 2 | Recommendation | Recommended |  | Not recommended  (If not recommended, state reason in separate sheet) |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of HOD Date

**RECOMMENDATION BY CREDENTIALING & PRIVILEGING TECHNICAL COMMITTEE**

This Application: Recommended Not Recommended

Comments : ................................................................................................................................................

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**Chairman of Technical Credentialing & Privileging Committee**

Date : .........................................................

**APPROVAL BY CREDENTIALING & PRIVILEGING COMMITTEE**

This Application: Recommended Not Recommended

Comments : ................................................................................................................................................

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**Chairman of Credentialing & Privileging Committee**

Date : .........................................................

Certificate Issued On : ...........................

Serial No. Of Certificate : .......................