**APPLICATION FOR CREDENTIALING & PRIVILEGING**

**HOSPITAL UiTM**

**(EXTERNAL/VISITING SPECIALIST)**

1. **PERSONAL DETAILS**

|  |  |  |
| --- | --- | --- |
| 1 | Name |  |
| 2 | Address |  |
| 3 | Telephone (Office) |  |
| 4 | Telephone (Personal) |  |
| 5 | E-mail address |  |
| 6 | Current Employee |  |
| 7 | Current Position |  |

**B PROFESSIONAL QUALIFICATIONS:**

|  |  |  |  |
| --- | --- | --- | --- |
| No. | Qualification (Bachelors degree/ Masters/ Fellowship/ Diploma/ Post Basic etc.) | Place (University/ College etc.) | Year |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

**C REGISTRATION**

**1. For Medical Practitioner**

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Type of registration** | **Date** | **Registration number** |
| 1 | MMC Full Registration |  |  |
| 2 | Annual Practicing Certificate |  |  |
| 3 | NSR Registration  |  |  |
| 4. | Credentialing and Privileging Certificate (Please provide copy) |  |  |

**D REQUEST FOR APPROVAL OF PRIVILEGES**

I would like to apply for the staff position and its corresponding privileges listed below to enable me to perform clinical functions in Hospital UiTM.

|  |  |
| --- | --- |
| **A.** Staff Position |  |
| **B.** Specialty Area |  |
| **C.** Core Privileges (broad area, e.g. Medicine) |  |
| **D.** Special Privileges (in area) |  |
| **E.** Research |  |

Have the privileges you are requesting been granted to you at previous place of employment?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

**E PROFESSIONAL INSURANCE COVER (if available)**

**1. Professional Insurance Cover**

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Professional Insurance CoverIf yes, provide letter of undertaking | Yes | No |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name of Insurance provider | Policy Number | Period of cover |
| 1 |  |  |  |
| 2 |  |  |  |

**F NAME OF REFEREES**

|  |  |  |
| --- | --- | --- |
| 1 | Name of Referee |  |
| Designation |  |
| Mailing address |  |
|  |  |
| Phone contact |  | E-mail address |  |
| 2 | Name of Referee |  |
| Designation |  |
| Mailing address |  |
|  |  |
| Phone contact |  | E-mail address |  |

I authorize the Hospital UiTM Credentialing & Privileging Committee 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.

I hereby certified all the above information is true.

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

 Signature of Applicant Date

**APPLICANT APPRAISAL BY EMPLOYER**

**A OVERALL RECOMMENDATION FOR PRIVILEGES REQUESTED**

|  |  |
| --- | --- |
|  |  Yes |
|  |  No |

**General Comments:**

**B VERIFICATION BY EMPLOYEE’s PIC**

Signature :

Name :

Position :

Department/Institution:

Contact No :

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 : .......................