

CHECKLIST FOR CREDENTIALING & PRIVILEGING APPLICATION SPECIALIST

NAME :

DEPARTMENT :

IC :

|  |  |  |  |
| --- | --- | --- | --- |
| **NO** | **SUBJECT** | **YES** | |
| **Applicant** | **Secretariat** |
| 1 | APPLICATION FORM |  |  |
| 2 | CURRICULUM VITAE WITH PHOTOGRAPH |  |  |
| 3 | COPY OF MMC FULL REGISTRATION |  |  |
| 4 | COPY OF LATEST APC |  |  |
| 5 | COPY OF NSR |  |  |
| 6 | COPY OF ACADEMIC QUALIFICATIONS |  |  |
| 7 | COPY OF C&P CERTIFICATE FROM OTHER HOSPITAL  (if any) |  |  |
| 8 | CREDENTIALING BY MOH/GAZETTMENT LETTER |  |  |
| 9 | EVIDENCE OF COMPLETION OF RESIDENCY PROGRAM OR STRUCTURED TRAINING  (if applicable) |  |  |
| 10 | CHECKLIST OF CORE PROCEDURE OR SPECIALISED PROCEDURE |  |  |

**APPLICATION FOR CREDENTIALING & PRIVILEGING**

**HOSPITAL UiTM**

1. **PERSONAL 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 |  | | | |

**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. | Gazettement (Clinical Specialist) |  | x |

**2. For Nurses, Assistant Medical Officer and AHP**

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Type of registration** | **Date** | **Registration number** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |

**D C URRENT OR P REVIOUS CREDENTIALING AND PRIVILEGING**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Credentialing body (Hospital/Institution)** | **Specialty Credentialed** | **Date** | |
| **From** | **To** |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |

**E RESEARCH/ PAPER PUBLISHED/ PRESENTATION/ SPECIAL INTERESTS**

|  |  |
| --- | --- |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |

**F PROFESSIONAL INSURANCE COVER**

**1. Professional Insurance Cover**

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

**2. Cover by Insurance Provider**

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

**G 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 |  |

If Yes please specify:

|  |
| --- |
|  |

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 in separate sheet)

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

**H 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 HOD/SUPERVISOR**

**HOSPITAL UiTM**

**A PLEASE PROVIDE THE FOLLOWING INFORMATION**

Please complete the following assessment of the applicant’s ethical and professional qualifications.

**Please tick (√) at the appropriate box.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Below Average** | **Average** | **Above Average** |
| Clinical knowledge |  |  |  |
| Clinical skills |  |  |  |
| Professional Clinical Judgement |  |  |  |
| Sense of clinical responsibility |  |  |  |
| Ethical conduct |  |  |  |
| Cooperativeness, ability to work with others |  |  |  |
| Documentations/Medical record  timeliness & quality |  |  |  |
| Teaching skills |  |  |  |
| Compliance with hospital rules & regulations |  |  |  |

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

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

1. Has this applicant ever been suspended, disciplined or has his/her privileges voluntarily or involuntarily restricted or not renewed?

□ Yes □ No

1. To your knowledge, does this applicant have any existing health problems that could affect his/her medical practice?

□ Yes □ No

B **OVERALL RECOMMENDATION FOR PRIVILEGES REQUESTED**

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

**General Comments:**

Signature

Title

Name of Institution/Hospital

Phone Number

Date

**RECOMMENDATION BY CREDENTIALING & PRIVILEGING TECHNICAL COMMITTEE / DEPARTMENT C&P SUBCOMMITTEE**

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