CHECKLIST FOR CREDENTIALING & PRIVILEGING

(POSTGRADUATE STUDENT FROM ANOTHER UNIVERSITY)

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 LOGBOOK		
6	COPY OF ACADEMIC QUALIFICATION		
7	COPY OF C&P CERTIFICATE FROM OTHER HOSPITAL (including the list of procedure privileged)		
8	COPY OF LOGBOOK AND RECOMMENDATION LETTER FROM THE SUPERVISOR (if the applicant does not have C&P certificate from the previous hospital)		

**New applicants/new staff should only complete pages 1-4 of the application form

APPLICATION FOR CREDENTIALING & PRIVILEGING
HOSPITAL UiTM

A. 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	Yes	No
	If yes, provide letter of undertaking		

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?

   _____

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

   □ Yes □ No

3. 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 : .....

.....

Chairman of Technical Credentialing & Privileging Committee

Date : .....

APPROVAL BY CREDENTIALING & PRIVILEGING COMMITTEE

This Application: [ ] Recommended [ ] Not Recommended

Comments : .....

.....

Chairman of Credentialing & Privileging Committee

Date : .....

Certificate Issued On : .....

Serial No. Of Certificate : .....