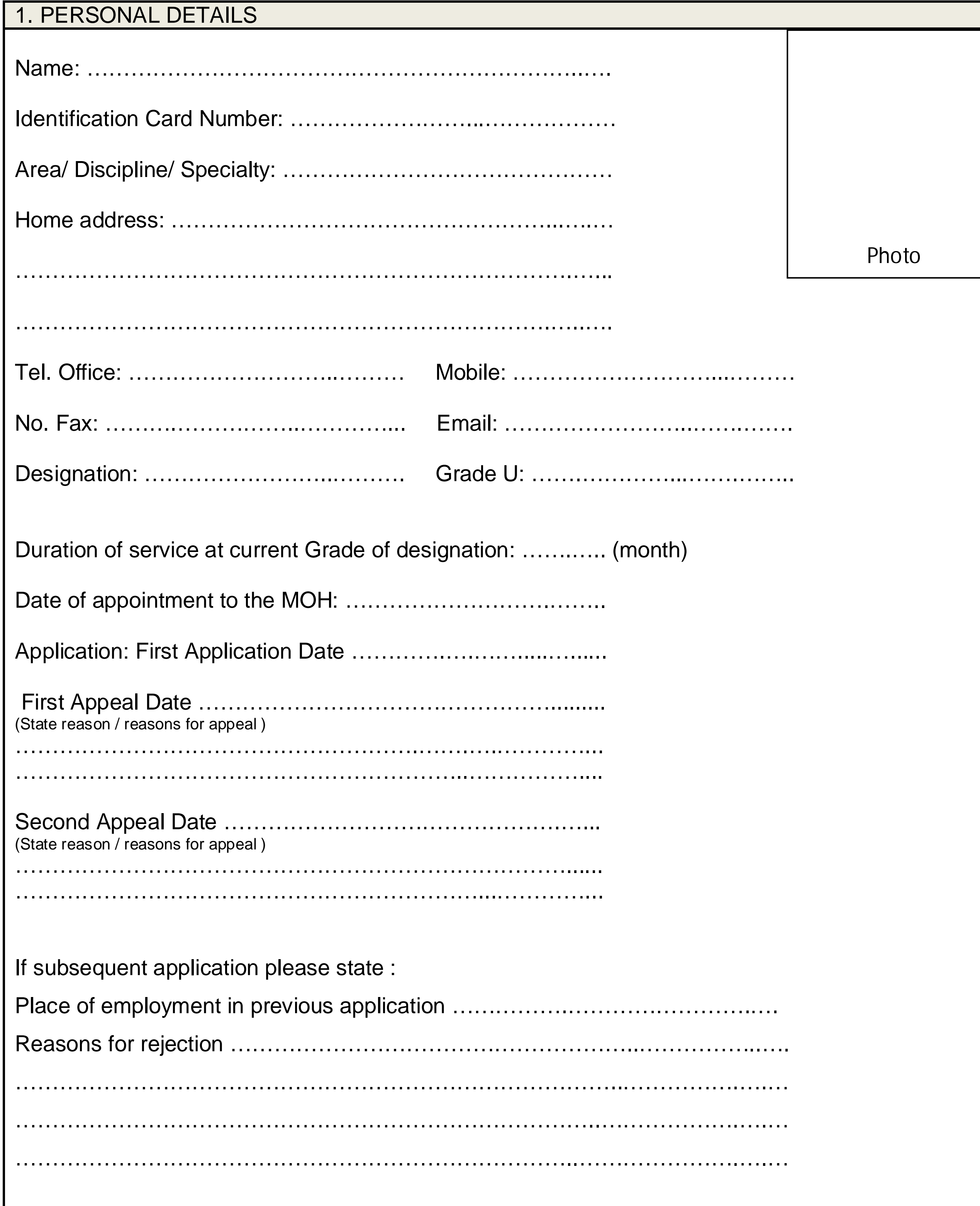
Appendix AHP 6

APPLICATION FOR CREDENTIALING

HOSPITAL: ___________________________________

DATE OF APPLICATION: ________________________



1. PERSONAL DETAILS

Name: ……………………………………………………………………

Identification Card Number: ……………………………………………

Area/ Discipline/ Specialty: ……………………………………………

Home address: …………………………………………………………

……………………………………………………………………………

……………………………………………………………………………

Photo

Tel. Office: ……………………………… Mobile: ………………………………

No. Fax: ………………………………… Email: ………………………………

Designation: ……………………………… Grade U: ……………………………

Duration of service at current Grade of designation: ……….. (month)

Date of appointment to the MOH: ……………………………………

Application: First Application Date ……………………………………

First Appeal Date ………………………………………………………
(State reason / reasons for appeal)
……………………………………………………………………………
……………………………………………………………………………

Second Appeal Date ……………………………………………………
(State reason / reasons for appeal)
……………………………………………………………………………
……………………………………………………………………………

If subsequent application please state :

Place of employment in previous application …………………………………

Reasons for rejection …………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

2. CURRENT PROFESSIONAL STATUS (start from the current)		
Professional Qualifications:		
Diploma / Degree / Masters, etc.	University/ Colleges, etc.	Year of qualification

(Please attach certified copies of any qualifications detailed in the form)

3. RELATED TRAINING / COURSES			
Type of Training	Institution	Duration	Year

(Please attach certified copies of any trainings detailed in the form)

4. WORKING EXPERIENCE (start from the current)				
Area of practice	Department	Institution	Duration (month)	Year

(If more space is needed, please list on a separate sheet)

Continuing Education
(Relevant educational seminars, courses, etc. attended within the last 3 years. Attach document that will support application.

5. REGISTRATION
Date of Full Registration with: • AHP Council Malaysia : ☐ Are you currently registered to practice in Malaysia : Yes: ☐ No: ☐ If yes, current Practising Certificate number: * Year : Number : Date of expiry:

* Attach copy

6. APPLICATION FOR RECOGNITION OF CREDENTIALS
(Please (√) in the appropriate box) DIAGNOSTIC RADIOGRAPHER ☐ PHYSIOTHERAPIST ☐ RADIATION THERAPIST ☐ DENTAL TECHNOLOGIST ☐ OCCUPATIONAL THERAPIST ☐ I apply for my credentials to be recognised as detailed below: i) Core Procedures ☐ ii)Specialised Procedures ☐ a) ……………………………….. b) …………………………….... c) ………………………………… d) ………………………………… e) ………………………………… f) ………………………………… iii)Optional Procedures ☐ a)………………………………….. b)………………………………….. c)………………………………….. d)…………………………………..

(Please attach summary of procedure done)

7. Please list at least two referees familiar with your clinical skills		
NAME	POSITION	PLACE OF WORK

I authorize the National Credentialing Committee and Hospital ___________ 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 hereby declare that all the information given herein are true and correct. Signature of applicant:……………………. Date:……………………….

Appendix AHP 6(a)

APPLICATION FOR CREDENTIALING

NAME: ________________________

<table>
<tr><td>I request to be credentialed in:

a) Core procedures in (area) ___________________________

b) Specialised Procedure ______________________________

c) Optional procedures _______________________________

d) Have completed additional education, certification or training in addition to CME in the past two years?

YES ☐ NO ☐

If ‘YES’ please specify on a separate sheet</td></tr>
<tr><td>I request for approval of credentialing as indicated on the attached form.

Signature of applicant : ____________________

Date : ______________</td></tr>
<tr><td></td></tr>
</table>