HSDG\_PRIV\_RENEW

**APPLICATION FOR RENEWAL OF CLINICAL PRIVILEGES**

**HOSPITAL SERDANG**

**SECTION A: Personal Details**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I/C No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MMC No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Position:

Jusa A/B/C Consultant Specialist

Medical Officer Nursing/ Allied Health

**Request for Approval of Privileges**

Type of Request: Triennial Renewal

1. I request privileges in:

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

**SECTION B: Current Professional Status**

Date of Gazettement/ Special Registration of Basic Specialty (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Gazettement/ Special Registration of Subspecialty (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Credentialing (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **NAME** | **POSITION** | **ADDRESS** |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list at least two peer’s familiar with your clinical skills.**

**Other Information**

*(Include any additional information that you wish to bring to the attention of the Hospital Privileging Committee.)*

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

**I request approval for the Clinical Privileges indicated on the form for the period of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please indicate date).**

**Signature of Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*REQUEST REVIEWED BY PEER/PHYSICIAN; COMPETENCY OF THIS APPLICANT HAS BEEN CONSIDERED AND THE INDIVIDUAL HEALTHCARE PROVIDER’S DECLARATION OF HEALTH STATUS HAS BEEN CONFIRMED. THE FULL RANGE OF PRIVILEGES FOR HIGH RISK PROCEDURES. EVALUATION OF PROFESIONAL PERFORMANCE, JUDGEMENT AND CLINICAL AND/OR TECHNICAL SKILLS IN AREAS SPECIFIED HAS BEEN COMPLETED. THE INDIVIDUAL IS ENTITLED TO RETAIN THE REQUIRED PRIVILEGES BASED ON AVAILABLE, RELEVANT RESULTS OF ONGOING APPRAISALS OF CLINICAL PERFORMANCE AND PRACTICES.*

*AS THE HEAD OF DEPARTMENT, I HAVE REVIEWED WITH THE APPLICANT THE SPECIFIC PROCEDURES AND/OR TREATMENTS THAT ARE BEING REQUESTED. ISSUES SUCH AS DOCUMENTED CHANGES IN THE HOSPITAL/FACILITY MISSION, FAILURE TO PERFORM A SUFFICIENT NUMBER OF OPERATIONS AND/OR PROCEDURES TO MAINTAIN PROFICIENCY, OR FAILURE TO USE PRIVILEGES PREVIOUSLY GRANTED HAVE BEEN TAKEN INTO CONSIDERATION IN THE RECOMMENDATION FOR RENEWAL OF PRIVILEGES.*

NARRATIVE OR CURRENT PROFICIENCY ATTACHED.

**RECOMMEND**: APPROVAL/DISAPPROVAL (If disapproved, state reason.)

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

SIGNATURE OF HEAD OF DEPARTMENT DATE

**DECISION:**

**REVIEWED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPROVED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MODIFICATIONS TO ABOVE PRIVILEGES: YES NO

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

**CHAIRMAN**  DATE

**HOSPITAL PRIVILEGING COMMITTEE**