	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Document Code: HSAAS/UKPR/BR78**
	APPLICATION FOR RENEWAL OF CLINICAL PRIVILEGES FORM

SECTION A: Personal Details

Name _____

Service/Specialty _____

Department _____

Staff Position:

Consultant ☐ Clinical Specialist ☐ Specialist ☐

Medical Officer ☐ Nursing/ Allied Health ☐

Request for Approval of Privileges

Type of Request: ☐ Triennial Renewal

a) I request privileges in:

_____

_____

_____

b) 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.

SECTION B: Current Professional Status

The following information is offered in support of the request for renewal of clinical privileges. Please answer each question as it applies to the period of time since your last approval of privileges.

For any questions answered "YES", provide complete information on a separate sheet of paper and attach to this request.

Since Your Last Approval of Privileges

Membership in professional organizations (Membership, Fellowship, Medical Society)

_____
_____

Current appointments in a teaching institution

_____
_____

Have you been granted privileges at any additional hospitals? If so list.

_____

Please provide a listing of CME that support requested clinical privileges.
(Attach a separate sheet if necessary)

_____
_____
_____

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

NAME	POSITION	ADDRESS

Other Information

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

_____

_____

Physical and Mental Health

Have you had any problems with your health status, which might affect your ability to carry out your clinical privileges at this hospital?

If Yes, comment on a separate piece of paper YES ☐ NO ☐

Have you been hospitalised in the last two years for anything that would interfere with your ability to carry out your duties?

YES ☐ NO ☐

Name of personal physician if you have answered "YES" to above. (Give address and phone number.)

_____

In the past have you had voluntary or involuntary suspension, limitation, reduction or loss of clinical privileges at another hospital, not renewed or voluntarily relinquished?

YES ☐ NO ☐

If "YES" please give details.

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 & STAMP
HEAD OF DEPARTMENT

DATE

DECISION:

REVIEWED: _____ APPROVED: _____

MODIFICATIONS TO ABOVE PRIVILEGES: **YES** ☐ **NO** ☐

_____ _____

CHAIRMAN
HOSPITAL PRIVILEGING COMMITTEE

DATE