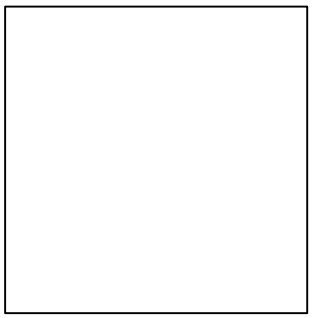
APPLICATION FOR LETTER OF CREDENTIALING AND PRIVILEGING (CHAPTER 2)

1. PERSONAL DETAILS



Full Name : _____

NRIC / Passport No. : _____

Malaysian Medical Council Reg. No. : _____

Current Annual Practicing Certificate No. /Year : _____

Clinic/Hospital Name : _____

_____

_____

Home Address : _____

_____

Telephone No. Office : _____ Residence: _____ Mobile: _____

Fax No. : _____

Email Address : _____

2. PERSONAL QUALIFICATION / TRAINING

2.1 Basic Qualification:

Qualification : _____

University/Awarding body : _____

Date of Qualification : _____

2.2 Post Graduate Qualifications: (If applicable)

Qualification : _____

University/Awarding body : _____

Date of qualification : _____

Years of aesthetic medical practice experience (part time/full time): _____

2.3 Information on Professional Indemnity

***Note*: It is recommended that medical practitioners performing aesthetic medical practice have sufficient and appropriate professional indemnity to safeguard patients' interests.**

Name of insurance provider : _____

Type of insurance : _____

Start date of insurance : _____

Period of insurance : _____

3. DECLARATION TO PERFORM AESTHETIC MEDICAL PROCEDURES

Please attach with this application form, a copy of the certificate obtained (overseas or local training), details of training courses, organizers, trainer(s)' name and CV if necessary, details of hands-on experience, duration of course and examinations / tests.

Type of Treatment and Procedure	Tick	No. of Procedures Performed	Name of Trainers/Supervisors	Title of Certificate Obtained
NON INVASIVE				
Chemical peel (Superficial)				
Microdermabrasion				
Intense pulsed light (IPL)				

Type of Treatment and Procedure	Tick	No. of Procedures Performed	Name of Trainers/Supervisors	Title of Certificate Obtained
MINIMALLY INVASIVE				
Chemical peel (Medium depth)				
Botulinum toxin injection				
Filler injection – excluding silicone and fat				
Superficial Sclerotherapy				
Lasers for treating skin pigmentation				
Lasers for skin rejuvenation (including fractional ablative)				
Lasers for hair removal (e.g long – pulsed Nd-YAG, Diode)				
Skin tightening procedure- radiofrequency, ultrasound, infrared up to upper dermis				
INVASIVE				
Laser for treating vascular lesions				
Chemical peels (Deep)				
Ablative skin resurfacing lasers				
Hair transplant				
Phlebectomy				
Ultrasound device				
Tumescent Liposuction				

Note :
This list is subject to review whenever there is new evidence-based treatment available.

Additional Information on the Certificate(s) / Training

Title of Certificate Obtained	Year Obtained	Name of Organiser	Details of Hands on Experience	Name(s) of supervisors/ Trainers	Duration	Details of any Examinations / Tests

4. NAME OF REFEREES

Please list at least two referees familiar with your clinical skills

Name : _____

IC / Passport No. : _____

Designation : _____

Telephone No. Office : _____ Residence: _____ Mobile: _____

Fax No. : _____

Email Address : _____

Name : _____

IC / Passport No. : _____

Designation : _____

Telephone No. Office : _____ Residence: _____ Mobile: _____

Fax No. : _____

Email Address : _____

5. DECLARATION

I declare that the information provided in this application form is true and authentic and herein remains unchanged to-date. To the best of my knowledge and belief, I have not withheld any material fact. I understand that my practice may be audited. I also note that I may be required to submit additional details for further assessment / review.

_____ _____

Name of Medical Practitioner Date

_____

Signature

Please submit your application form and supporting documents to:

Cosmetic Dermatology and Laser Medicine Board
(Dermatological Society of Malaysia),
Academy of Medicine of Malaysia,
Unit 3.8, Level 3, Medical Academies of Malaysia
No. 5, Jalan Kepimpinan P8H
62250 Putrajaya

Email: admin@dermatology.org.my
Tel : 03-8800 0000 / 8800 0779

6. FOR OFFICE USE ONLY

6.1 Evidence of adequate training

Please tick the appropriate box Yes ☐ No ☐

6.2 Overall recommendation for procedures requested

Please complete the following recommendation for procedures requested

List of procedures	Recommend highly	Recommend without reservation	Recommend with some reservation	Do not recommend

6.3 Comments/suggestions:

_____

_____

_____

_____

_____

_____ _____

Name of chairman Signature

_____ _____

Designation Date