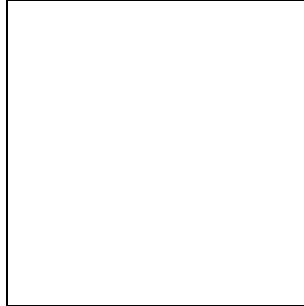
AMP-BOR-01(B)

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 : ____

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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 Work Experience

PERIOD	PLACE OF PRACTICE	POSITION

2.4 Information on Professional Indemnity

Name of insurance provider : ____

Type of insurance : ____

Start date of insurance : ____

Period of insurance : ____

***Note*: Upon approval of the Letter of Credentialing & Privileging, medical practitioners performing aesthetic medical practice should have appropriate professional indemnity.**

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

Additional Information on Training (if any)

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

One referee must be a Malaysian who is a registered medical practitioner practicing aesthetic medical practice in Malaysia.

REFEREE 1

Name : ______________________________

IC / Passport No. : ______________________________

Designation : ______________________________

MMC No. : ______________________________

APC No. : ______________________________

LCP No.(if any) : ______________________________

Telephone No. : Office:__________ Residence: __________Mobile: __________

Fax No. : ______________________________

Postal Address : ______________________________

____

Email Address : ______________________________

Referee's Signature **:** ______________________________

REFEREE 2

Name : ______________________________

IC / Passport No. : ______________________________

Designation : ______________________________

MMC No. : ______________________________

APC No. : ______________________________

LCP No.(if any) : ______________________________

Telephone No. : Office :__________ Residence: __________Mobile: __________

Fax No. : ______________________________

Postal Address : ______________________________

____

Email Address : ______________________________

Referee's Signature **:** ______________________________

5. DECLARATION

I declare that the information provided in this application form is true 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
(Persatuan Dermatologi Malaysia)
C/O Unit 1-6, Level 1, Enterprise 3B
Technology Park Malaysia
Jalan Innovasi 1
Lebuhraya Puchong-Sungei Besi
Bukit Jalil
57000 Kuala Lumpur

Email: admin@dermatology.org.my

*** a processing fee is applicable (kindly refer to the above secretariat)**

6. FOR OFFICE USE ONLY

6.1 Evidence of adequate training

Please tick the appropriate box Yes ☐ No ☐

6.2 Recommendation for procedures requested

List of procedures	Recommendation		Remarks
	Yes	No	

6.3 Comments/suggestions:

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____

____
Chairman of Cosmetic
Dermatology and Laser Medicine Board
( )

____
Date

____
Committee Member of Cosmetic
Dermatology and Laser Medicine Board
( )

____
Date