

CP(HQE II)-2

APPLICATION FOR *RENEWAL/ADDITIONAL/REDUCTION OF CLINICAL PRIVILEGES QUEEN ELIZABETH II HOSPITAL.

DEPARTMENT OF :

FROM _____ TO _____

**delete if not applicable*

PERSONAL DETAILS

Name :

I/C or Passport No.:

Designation :

1.0 ADDITIONAL PROFESSIONAL STATUS SINCE LAST APPROVAL.

Professional Qualification:

Post-basic / Diploma / Degree/ Masters / etc.	University / Colleges	Year of Qualification

2.0 REGISTRATION

Current Annual Practicing Certificate No. :

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3.0 PHYSICAL AND MENTAL HEALTH.

3.1 Have you had any problems with your health status, which might affect your ability to carry out your clinical privileges at this hospital? **YES / NO**

3.2 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**

4.0 PLEASE LIST AT LEAST 2 (TWO) PEERS FAMILIAR WITH YOUR CLINICAL SKILLS.

Name	Position	Address
1.		
2.		

5.0 TYPE OF REQUEST:

Procedure for privileges	Renewal	Additional	Reduction
Core privileges			
Special privileges			
Unusual			

I have reviewed the competency of this applicant and support his/her application for:

Re-privileging for the previous procedure foryear/s

Additional privileging for core/special procedures as follows:

No.	Procedures	Years
1.		
2.		
3.		
4.		
5.		

**attach separate sheet if necessary*

6.0 PRIVILEGING FOR UNUSUAL PROCEDURE/S AS FOLLOWS :

No.	Procedures	Years
1.		
2.		
3.		
4.		
5.		

**attach separate sheet if necessary*

.....
Head of Department

.....
Date

7.0 DECISION BY HOSPITAL PRIVILEGING COMMITTEE.

Approved ALL : **YES / NO**

Modifications or approved part of above privileges request as below :

No.	Procedures	Years	Comment
1.			
2.			
3.			
4.			
5.			

.....
Chairperson	Date
Hospital Privileging Committee	

upkhqe2@gmail.com/UnitPengurusanKlinikal/HospPrivilegingHqe2