HOSPITAL QUEEN ELIZABETH KOTA KINABALU

DEPARTMENT OF .....

APPLICATION FOR *RENEWAL/ADDITIONAL/REDUCTION OF CLINICAL PRIVILEGES FROM _____TO_____

*delete if not applicable

1. Personal Details

Name: .....

I/C or Passport No.: .....

Designation: .....

2. Additional Professional Status since Last Approval

Professional Qualifications:

Postbasic / Diploma / Degree / Masters / etc.	University / Colleges	Year of Qualification

3. Registration

Current Annual Practicing Certificate No.: .....

4. 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? YES / NO
- 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

5. Please list at least 2 peers familiar with your clinical skills.

NAME POSITION ADDRESS

_____

_____

_____

6. Type of request:

Procedure for privileges	Renewal	Additional	Reduction
Core privileges			
Special privileges			
Unusual			

**attach supporting document if available*

**attach separate sheet if necessary*

....

Signature of Applicant Date

Additional comment by Head of Department:

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

1. reprivileging for the previous procedure for ..... year/s.
2. additional privileging for core/special procedure/s as follows:

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

**attach separate sheet if necessary*

3. privileging for unusual procedure/s as follows:

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

**attach separate sheet if necessary*

....

Head of Department Date

Decision by Hospital Privileging Committee

Approved all : YES / NO

Modifications or approved part of above privileges request as below:

	Procedures	Years

.....

Chairperson

Hospital Privileging Committee

.....

Date