Gambar

MAKLUMAT PERIBADI PAKAR/PEGAWAI PERUBATAN DI HOSPITAL-HOSPITAL KEMENTERIAN KESIHATAN MALAYSIA

PROVIDER PROFILE

IC (New) :……

First Name :……

Last Name :……

Private Address :……

Postcode :……

City :……

State :……

Sex :……

Race :……

Date Of Birth :……

Age :……

Email :……

Phone (residence) :……

Cellular :……

Marital Status :……

Citizenship :……

Date of Full Registration with MMC (date/m/year) :……..

Date of Appointment into service (date/m/year) :……..

Number of Full Registration :……..

Date of last Promotion(date/m/year) :……..

Current Grade :……..

Spouse Name :……..

Occupation of Spouse :……..

Office address of Spouse :……..

(note: Please state also whether :……..

spouse is MOH staff or not) .....

CURRENT PLACEMENT

Department :……

Hospital / Institution :……

State :……

Types of Service : **State Hospital** ☐

(Please tick where appropriate) **District Hospital with specialist** ☐

District Hospital without specialist ☐

Status of Employment : **Permanent** ☐

(Please tick where appropriate) **Contract** ☐

Current Position : **Senior Consultant** ☐

(Please tick where appropriate) **Consultant** ☐

Specialist ☐

Medical Officer ☐
(with Post - Graduate qualification)

Medical Officer ☐
(without Post - Graduate qualification)

BASIC MEDICAL TRAINING

Basic Degree

University/Medical School :……

Year of Qualification :……

Housemanship

Place of Housemanship Training :……

(If more than 1(one) hospitals please list other training centers)

Place	**Year**
1)……	**……**
2)……	**……**
3)……	**……**

Placement during Basic Medical Training

HOUSEMANSHIP

Discipline	**Place**	**Date (Duration in month)**
Internal Medicine		
O&G		
Surgery		
Pediatric		
Orthopeadic		
Others (please list)		

MEDICAL OFFICER

Year:……..to……

Discipline	**Place**	**Consultant**	**Date (Duration in month)**
Internal Medicine			
O&G			
Surgery			
Pediatric			
Orthopeadic			
Others (please list)			

POST GRADUATE TRAINING

Specialist Training

Year of Qualification :……

Qualification/ Degree :……

Discipline :……

University /Awarding Body :……

Undergoing gazettment training:

No ☐

Yes ☐

Completed ☐

If yes, date of commencement of training:……..

Date of gazettment (date/m/year) **:……..**

Duration of gazettment (month) **:……..**

Placement after completion of Specialist Training:

Date (From….to…..) (d/m/year)	Hospital	Duration (months)

Fellowship Training (Subspecialty Training)

Undergoing Training :Yes / No
If Yes,
Discipline :……
Date of Commencement of training :……..
(date/m/year)
Training number, if applicable:…….
Place and duration of training that you have undergone

Date (From….to…..) (d/m/year)	Hospital	Name of Trainer	Duration (months)

Any overseas training :……

If Yes,

Area of Training :……

Place of Training :……

Trainer :……

Period of Training :…… to……..

(date/m/year)

If you have completed training,

Certifying Body :……

Date of Completion :……

(date/m/year)

Date of gazettment for :……

subspecialty if applicable

(date/m/year)

Placement after completion of Fellowship Training (Subspecialty Training)

Date (From….to…..) (d/m/year)	Hospital	Duration (months)