APPLICATION FOR LETTER OF CREDENTIALING AND PRIVILEGING (CHAPTER 3)

1. PERSONAL DETAILS

Photo

Full Name :

NRIC / Passport No :

Malaysian Medical Council Reg. No :

NSR 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 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 (log book), duration of course and examinations/tests.

Scope of Practice and Requirements for Surgical Specialists:
Surgical Modalities

Type of Treatment and Procedure	Tick	No. of Procedures Performed	Name of Trainers/Supervisors	Title of Certificate Obtained
Abdominoplasty				
Blepharoplasty-Upper eyelid Lower Eyelid				
Breast Implant				
Breast enhancement (other than implant)				
Breast reduction				
Brow Lift				
Fat Grafting				
Type of Treatment and Procedure	**Tick**	**No. of Procedures Performed**	**Name of Trainers/Supervisors**	**Title of Certificate Obtained**
Hair Transplant				
Implant - Face				
Implant – Nose				
Lasers, Ablative (Including fractional & resurfacing)				
Liposuction (LA & < 1 Litre aspirate) Liposuction (GA/ >1 Litre)				
Rhinoplasty				
Rhytidectomy				

Facelift				
Mini Lift				
Thread Lift				
Phlebectomy				

Note :

This list is subject to review.

Scope of Practice and Requirements for Surgical Specialists:
Non-Surgical Modalities

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)				
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 pulse Nd:YAG, Diode)				
Skin tightening procedures – radio frequency, ultrasound, infrared up to upper dermis				
INVASIVE				
Lasers for treating vascular lesions				
Chemicals peels (Deep)				
Radiofrequency (External application)				
Ultrasound device (External application)				

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

Please list at least two referees (LCP 3 holders) familiar with your clinical skills

REFEREE 1

Name :

IC / Passport No :

Designation :

MMC No :

APC No :

LCP No :

Telephone No :

Fax No :

Postal Address :

Email Address :

Referee's Signature

REFEREE 2

Name :

IC / Passport No :

Designation :

MMC No :

APC No :

LCP No :

Telephone No :

Fax No :

Postal Address :

Email Address :

Referee's Signature

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:

Corresponding Address :

MSPRS LCP 3 Secretariat
Malaysian Society of Plastic & Reconstructive Surgery
Unit 3-8, 3RD Floor, Medical Academies of Malaysia
No.5, Jalan Kepimpinan P8H, Presint 8
62250 W. P Putrajaya, Malaysia.
Tel: 603 8996 0700; 603 8996 1700; 603 8996 2700
Fax: 603 8996 4700

Official Website : https://msprs.org.my/
Email Address : secretariat@msprs.org.my

Please enclose payment of RM 500 as processing fee to MSPRS Account details as below:

Name of Bank	: CIMB ISLAMIC BANK BHD
Branch	: KLCC BRANCH
Address of Bank	: Lot C04-C05, Concourse Level, Petronas Tower 3, Suria KLCC, Kuala Lumpur
Account Number	: 86-0005729-8
Swift Code	: CTBBMYKLXX

Documents need to be submitted together:

1. National Specialist Register (NSR) certificate
2. MMC Full Registration Form
3. Undergraduate degree and post-graduate degree qualification
4. Current APC

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:

_____

_____

_____

_____

_____

_____ _____

Chairman
Joint Committee for
Aesthetic Medical/Surgical Practice
( )

Member
Joint Committee for
Aesthetic Medical/Surgical Practice
( )

_____ _____

Date Date

Documents need to be submitted