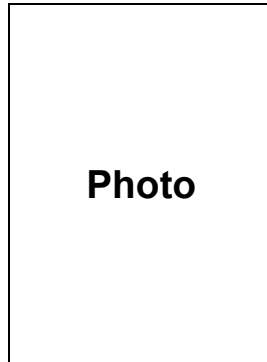


**APPLICATION FOR LETTER OF CREDENTIALING AND PRIVILEGING
(CHAPTER 3)**

1. PERSONAL DETAILS



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