Appendix CP6

REAPPRAISAL BY HEAD OF DEPARTMENT
FOR RENEWAL OF CLINICAL PRIVILEGES
HOSPITAL KLUSTER PAHANG TENGAH

STAFF'S NAME : _____

DEPARTMENT : _____

PERIOD COVERED : _____

ADDITIONAL INFORMATION REQUIRED FOR "NO" ANSWERS

Please Tick [√] the appropriate box

	YES	NO
1. Have the individual's clinical and / or technical skills been observed and evaluated	☐	☐
2. Does the individual exercise appropriate professional judgement and performance	☐	☐
3. Does the individual show positive evidence of contributions to patient care and Quality assurance?	☐	☐
4. Does the individual have an acceptable attitude toward patients, medical and other members of the Hospital Staff?	☐	☐
5. Timely completion and preparation of medical and other required patient records	☐	☐
6. Does the individual actively participate in department and Hospital activities?	☐	☐
7. Does the individual attend at least 60% or more of all scheduled department / committee meeting?	☐	☐
8. Should the individual's requested clinical privileges be approved?	☐	☐
9. Does the individual exercise ethical conduct?	☐	☐
10. The individual is free of physical or mental disability or a change in health status, which would impact professional functioning?	☐	☐

SIGNATURE: …… ……

Head of Department Date