**Consent to Participate in NRR**

(Please return completed forms for registration)

*For office use: SDPID:*

*For office used*

Date:…………………….



Thank you.

Yours sincerely,

………………………… ………………………………….

*(Signature of doctor in-charge) (Centre Official Stamp)*

*Signatory’s Name*:…………………………….………… *Mykad No*…………..…/……/…………

|  |  |  |  |
| --- | --- | --- | --- |
|  | **National Renal Registry** | *For office use:* |  |
| **Malaysian Society of Nephrology** | *Tel/Fax:* | (603) 4050 2583 |
| **Haemodialysis Centre Registration (Borang 1)** | *e-mail* | [nrr@msn.org.my](mailto:nrr@msn.org.my) |

*Kepada yang menjaga:*

* *Isikan borang ini dengan lengkap kepada [nrr@msn.org.my](mailto:nrr@msn.org.my). . Pusat HD swasta perlu lampirkan satu salinan lesen CKAPS (Borang 4)*
* *Setiap staf berdaftar dengan eNRR sekali sahaja. Ini adalah akaun anda; akaun yang ini akan digunakan jika anda ada tambahan pusat atau pun sudah pindah ke pusat yang lain. Maklumat peribadi, nombor telefon bimbit dan emel staf adalah wajib.*
* *Staf yang berkelulusan bidang perubatan atau para-perubatan sahaja yang boleh mengendalikan maklumat-maklumat pesakit.*
* *Infomasi pusat dan staf yang dinamakan di borang ini nama anda akan tertera di Directory* <https://www.msn.org.my/nrr/centre_directory.jsp>. *Anda berkuasa menambahkan atau mengeluarkan penguna eNRR pusat anda..*
* *Jika maklumat pusat sudah ada dalam pendaftaran eNRR, pusat ini tidak akan didaftar semula.*

# **Haemodialysis Centre information** *(Isi gunakan komputer. Jangan tulis )*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Haemodialysis centre information: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Centre Name:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Classification:** | | |  | | | ARMED FORCE | | | | |  | | | MOH | | | | |  | | NGO | |  | | | | |
|  | | | PRIVATE | | | | |  | | | UNIVERSITY | | | | |  | | | | | | | | |
| **Centre Address*:*** | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Postcode: |  | | | | City/Town: | | | |  | | | | | | | | | State: | | | |  | | | | | |
| ***Tel (1):*** |  | | | | ***Ext:*** | | | |  | | | | | | | | | ***Tel (2):*** | | | |  | | | | | |
| ***Fax:*** |  | | | | ***e-Mail:*** | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| When did your centre begin to provide this service? | | | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_(dd/mm/yyyy): | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Akta Kemudahan dan Perkhidmatan Jagaan Kesihatan Swasta 1998 *(Lampirkan satu salinan yang terbaru)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *CKAPS license No.:* | | |  | | | | | | | | | | | | | | |  | | | | |  | | | | |
| *CKAPS Borang No.:* | | |  | | | | | | | | | | | | | | | *No. KPPN:* | | | | |  | | | | |
| **Management company information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Company name:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of director:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Business registration No.:** | | | | | | | *Registrar of company:* | | | | | |  | | | | | | | *Registrar of society:* | | | | | |  | |
| **Classification:** | |  | | Sole Proprietor | | | | | |  | | Society / NGO | | | |  | Government | | | | | | |  | | | Partnership |
|  | |  | | Corporate Body | | | | | |  | | Others: | | |  | | | | | | | | | | | | |
| Address*:* | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postcode: | |  | | | | | | City/Town: | | | | | |  | | | | | | | | *State:* | | |  | | |
| ***Tel (1):*** | |  | | | | | | ***Ext:*** | | | | | |  | | | | | | | ***Tel (2):*** | | | |  | | |
| ***Fax:*** | |  | | | | | | ***e-Mail:*** | | | | | |  | | | | | | | | | | | | | |

**2. Key personnel of the centre *(Maklumat*** *diri. Borang tidak penuh diisi tidak akan diproses)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Doctor in-charge Information *(Name as registered with CKAPS Licensing):*** | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  |
| ***Name of doctor in-charge:*** | | | | | | |  | | | | | | | | | | | | | | | | *Mykad No:* | | |  | | |
| *Mobile phone:* |  | | | | | | | | | | | | | *e-mail address:* | | | | |  | | | | | | | | | |
| **Doctor qualification: (Degree/Membership/Fellowship)** | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| Nephrologist | | | | Physician (MD) | | | | | | | | | | Medical officer (MBBS) | | | | | | | | | Others, specify: | | | | | |
| *National Specialist Register No.:* | | | | | | | |  | | | | | | | | | | | | | | |
| *Completed 200 hours training:*  *(A copy of 200 hrs trained certificate needed):* | | | | | | | | | | | | | *Date start:* | |  | | | | | | | *Date completed:* | | | | |  | |
| **Affiliated Nephrologist Information:** | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  |
| Nephrologist name: | | | | |  | | | | | | | | | | | | | | | | | | *Mykad No:* | | |  | | |
| *Mobile phone:* | | |  | | | | | | | | | | | e-mail address: | | | | | | | |  | | | | | | |
| *National Specialist Register No.:* | | | | | | | | |  | | | | | | | | | Date accredited nephrologist: | | | | | | |  | | | | |  | e-mail address: | …………………………………………… |
| **Centre Manager Information:** | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  |
| Name: |  | | | | | | | | | | | | | | | | | | | | | | *Mykad No:* | | |  | | |
| *Mobile phone:* |  | | | | | | | | | | | | | e-mail address: | | | | | | | |  | | | | | | |
| Academy qualification: | | | | | | |  | | | | Medical / paramedical | | | | | | | | | |  | | | Non-medical | | | | |
| If medical staff: | | Registered Nurse | | | | | | | | | | Registered Medical Assistant | | | | | | | | Others, specify: …………………………… | | | | | | | | |
| **If had Post Basic Renal Nursing :** *(Lampirkan satu salina sijil. Kosongkan jika anda belum ada kelulusan ini)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nursing school name: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Date completed training: | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | |
| **Centre Coordinator Information:** | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  |
| Name: |  | | | | | | | | | | | | | | | | | | | | | | *Mykad No:* | | |  | | |
| *Mobile phone:* |  | | | | | | | | | | | | | e-mail address: | | | | | | | |  | | | | | | |
| Academy qualification: | | | | | | |  | | | | Medical / paramedical | | | | | | | | | |  | | | Non-medical | | | | |
| If medical staff: | | Registered Nurse | | | | | | | | | | Registered Medical Assistant | | | | | | | | Others, specify: …………………………… | | | | | | | | |
| **If had Post Basic Renal Nursing :** *(Lampirkan satu salina sijil. Kosongkan jika anda belum ada kelulusan ini)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nursing school name: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Date completed training: | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |

**3. If you provide any of the following services, please register with NRR:**

CAPD / APD - Borang 2

Renal Transplant f/up – Borang 3

Renal biopsy - Borang 4

***Perhatian!***

* + - 1. *HD swasta, diminta lampirkan gambar lesen CKAPS diborang ini.*
      2. *PIC bukan pakar nefrologi, sila lampirkan sijil ’200 Hours trained certificate’.*
      3. *Demi PDPA, simpankan fail ini dengan “****Password****” sebelum pulangkan sebagai lampiran kepada NRR.*
      4. *Beritahu “****Password****” untuk buka lampiran ini melalui emel susuran; bukan email yang ada lampiran dokumen ini.*