**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  |

*Kepada yang menjaga:*

* *Isikan borang ini dengan lengkap kepada 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.*