**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** | *Telephone:* | 603-22763686  603-22763687 |
| **CAPD Centre Registration (Borang 2)** | *e-mail* | nrr@msn.org.my |

*Kepada yang menjaga:*

* *Isikan borang ini dengan lengkap dan pulangkan kepada [nrr@msn.org.my](mailto:nrr@msn.org.my).*
* *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.*

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Chronic PD care 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): | | | | | |
|  | | | | | | | | | | | | | |

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Nephrologist in-charge:** | | | | | | | | | | | | | | | |  | | | |  |
| 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: | | |  | | | | | |  | | | | | | | |
|  | |  | | | | | | | | | | | | | | |

***Perhatian!***

* + - 1. *Demi PDPA, simpankan fail ini dengan “****Password****” sebelum pulangkan sebagai lampiran kepada NRR.*
      2. *Beritahu “****Password”*** *untuk buka lampiran ini melalui emel susuran; bukan email yang ada lampiran dokumen ini.*