NOTIFICATION FORM FOR PLACE OF PRACTICE AND PERFORMED PROCEDURES

Name		:	
IC no		:	
Contact number		:	
Email address		:	
Place of work current hospital	Unit	:	
	Department		
	Hospital		
Exposure Prone Procedures (EPPs) performs		:	

I hereby declare that the information provided is true and correct. I also understand that disciplinary action may be taken against me according to Medical Act 1971 for any wrong information or wilful dishonesty.

COMPLETED BY;

……

Name :

Date :

VERIFIED BY;

……

Name of HOD :

Date :