



**MAJLIS PERUBATAN MALAYSIA**  
(MALAYSIAN MEDICAL COUNCIL)  
Kementerian Kesihatan Malaysia  
(Ministry of Health Malaysia)  
BLOK B, ARAS BAWAH  
JALAN CENDERASARI  
50590 KUALA LUMPUR

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## REFeree'S REPORT FOR APPLICATIONS TO SPECIALIST REGISTRATION

### SECTION I

Name of Applicant :  
I/C No. :  
Hospital/Institution :

### SECTION II (To be completed by the Referee)

Name of Referee :  
I/C No. :  
MMC Specialist Reg. No. :

**Note to Referee: Please ensure compliance with the following before writing a report for this applicant**

1. Referee must have a post-graduate qualification recognized in Malaysia
2. Referee must be a peer or senior professionally
3. Referee must have qualified as a specialist in the specialty for a minimum of 5 years
4. Referee must have worked with/had the opportunity to observe the applicant professionally after candidate completes the training programme
5. Referee must be MMC Specialist Registered except overseas referees
6. Referee must be from the respective specialty / fields of practice

|                                                                                                                                 |                                                    |                                                                                        |                                                              |                                       |
|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------|
| Your relationship to the applicant<br>(please tick where applicable)                                                            | <input type="checkbox"/> <b>Head of Department</b> | <input type="checkbox"/> <b>Supervisor</b><br>(After completion of training programme) | <input type="checkbox"/> <b>Other</b> (please specify) _____ |                                       |
| In what capacity does/did the applicant work for you or is known to you?                                                        |                                                    |                                                                                        |                                                              |                                       |
| The number of clinical encounters you observed while the applicant was working with/ for you.<br>(please tick where applicable) | <input type="checkbox"/> <5 years                  | <input type="checkbox"/> 5 – 10 years                                                  | <input type="checkbox"/> >10 years                           | <input type="checkbox"/> Not observed |
| When did supervision occur?<br>(approximate date and length of time)                                                            |                                                    |                                                                                        |                                                              |                                       |
| Which hospital was the applicant working in at the time?                                                                        |                                                    |                                                                                        |                                                              |                                       |
| Which clinical unit, discipline or specialty area was the applicant working in?                                                 |                                                    |                                                                                        |                                                              |                                       |

Please state your observations on the candidate's ability and suitability for registration as a specialist together with any other information, which might assist us in making decision. (Please use separate sheet, if necessary).

***Your comments will be treated with strict confidence. This report will in no circumstances be viewed or sent in by applicants.***

**1. Clinical Skills and Abilities**

**2. Medical/Surgical/Knowledge Skills and Abilities**

**3. Personal Character**

**4. Other Comments**

## **5. Recommendation**

I ☐ recommend/ ☐ not recommend \_\_\_\_\_  
(Please tick where applicable) (Applicant's Name)

to be registered in \_\_\_\_\_ in MMC Specialist Register  
(Specialty/Field of Practice)

I am willing to be contacted by the MMC for further discussion regarding this report:

☐

Yes

☐

No

Referee's Signature :

Date:

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Full Name of Referee :

Designation :

Hospital/Institution :

Contact Address :

Email Contact :

Official Stamp :

Mobile Tel No :

Office Tel No :

Office Fax No :

***Please ensure that ALL of the above details are completed.***  
Please return your completed report to [referee@mmc.gov.my](mailto:referee@mmc.gov.my)