CONFIDENTIAL

MALAYSIAN MEDICAL COUNCIL

NOTIFICATION FORM FOR PLACE OF PRACTICE AND PERFORMED PROCEDURES

NAME	:
IC NUMBER	:
CONTACT NO	:
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:

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

Verified by;

.....

Name & official stamp of Head of Department/
supervisor/ responsible physician: Date:

Endorsed in MMC 402 meeting on 19th January 2021
Second amendment by FTPC, and endorsed by *the Council at its 465 meeting* ***on*** *21* ***April 2026***