Consent to Participate in NRR
(Please return completed forms for registration)

SDPID: _____

For office used

Date:…….

To,
Chairman
NATIONAL RENAL REGISTRY
(MALAYSIAN SOCIETY OF NEPHROLOGY)
Suite 15-13A, VUE Residences
No. 102, Jalan Pahang
53000 Kuala Lumpur
Malaysia
Dear Sir,

Re: Participation in National Renal Registry (NRR)

A. My centre wishes to participate in NRR. I will undertake to:

1. Notify all current and future new dialysis patients in my centre to NRR promptly.
2. Provide regular update on my dialysis patients' clinical and outcome status.
3. Maintain a register book on all patients dialysing in my centre.
4. Appoint one of my nurses or medical assistants to be the co-ordinator for NRR activities.
5. Maintain and manage patients in the eMOSS.

B. I understand that:

1. My centre may be disqualified should it fail to report data on all patients or to regularly update information on patients in the centre.
2. Data reported by my centre will be used for analysis, the results of which will be reported in an Annual Report and other interim reports. Results will only be reported in aggregate form (that means, no centre specific data will be reported or data reported in such a manner that a centre may be identified.) However, information on centre's name, address, contact number, names of doctor and staff in-charge can be published in a directory of dialysis centres in Malaysia. No other information concerning my centre and my patients can be reported or published without my explicit consent.

C. I shall be responsible to NRR on matters related to confidential information by providing the following undertakings:

1. Account for all eMOSS users of my centre. I shall not at anytime or under any circumstances reveal their passwords to any unauthorized party and shall take all steps to prevent discovery and/or disclosure of the passwords by and/or to any unauthorized party.
2. My centre management and I shall indemnify, defend and hold NRR and the vendor company that develops the application harmless from and against any and all claims, demands, suits, actions, judgments, damages, costs, losses, expenses (including legal fees and expenses on a solicitor and client basis) and other liabilities arising from, in connection with or related in any way to the centre's lost or stolen User ID & Password; or any unauthorised access to your centre's data.

Thank you.

Yours sincerely,

…… …….
(Signature of doctor in-charge) *(Centre Official Stamp)*

Signatory's Name:…… *Mykad No*……..…/……/……

National Renal Registry
SDP Centre information Sheet

For office use:
Telephone: (603)4065 0107
Fax: (603) 4065 0107

Please provide your centre's information for office use:
Your centre information may be published in the directory.
The centre information shown here must be the same as CKAP licensing. Medical qualified staff will have access to eMOSS

1 Centre Information for correspondence: *(Select one* ☒ *where applicable)*

Name of Centre : ……

Name of management company:
(If applicable) ……

Name of person in-charge:
(Registered medical doctor as in CKAP licensing) …… *Mykad No:* ……/……/……

☐ Physician ☐ Nephrologist ☐ Others, specify:……

Mobile phone: …….. e-mail address: ……

Name of centre manager: …… *Mykad No:* ……/……/……

☐ Registered Nurse ☐ Registered Medical Assistant ☐ Others, specify: ……

Mobile phone: …… e-mail address: ……

Name of centre coordinator: …… *Mykad No:* ……/……/……

☐ Registered Nurse ☐ Registered Medical Assistant Other paramedics, specify: ……

Mobile phone: …… e-mail address: ……

Affiliated nephrologist:
(Registered medical doctor as in CKAP licensing) …… *Mykad No:* ……/……/……

Mobile phone: …… e-mail address: ……

Centre Address: ……
……..
……..
Postcode:..... *City/Town:*..... *State:*.....

Telephone (1): …… Ext: …… Telephone (2): ……

Fax: …… e-Mail: ……..

2. Please update this information regarding your centre. *Select one* ☒ *where applicable*

a. When did your centre commence operation? _____(dd/mm/yyyy):

b. How would you classify your centre?
☐ MOH ☐ MOE ☐ Armed Force ☐ Private ☐ NGO ☐ Others specify: ……..

c. Entrepreneurship: ☐ Sole proprietor ☐ Corporate body ☐ Partnership ☐ Society / NGO, specify :
☐ Others specify:
☐ Religious group
☐ Service organisation

3. Please update information regarding the Private Healthcare Facilities & Services Act 1998 [ACT 586] Regulation 2006 and provide a copy of the license upon submission of this form.

Please select one ☒ *where applicable. Please accompany this form with a copy of the CKAP licence.*

a.	Your business registration number.	Registrar of company: ……	Registrar of society: ……
b.	Your centre registration number with Ministry of Health Malaysia.	No. KPPN:	
c.	Received approved to Operate/Provide 'Borang 2' ☐ Yes ☐ No ☐ Not yet apply		
	License Number: ……	Date Expire *(dd/mm/yyyy):* ……	
d.	Received approved to establish/maintain 'Borang 4' ☐ Yes ☐ No ☐ Not yet apply		
	License Number: ……	Date Expire *(dd/mm/yyyy):* ……	

4. Please answer the following questions:

		Non-Hep	Hep. B	Hep C
a.	Number of patients on chronic haemodialysis program currently at your centre.			
b.	Total number of dialysis *station/RO point /*bays in your centre. *(An area where your patient can perform haemodialysis treatment)*			
c	How many of those dialysis *station* / bays actually in use?			
d.	Total number of functioning haemodialysis machines in your centre.			
e	Does your centre use an electronic medical record instead of the usual paper record? ☐ Yes, specify system: …… ☐ No			
f	Does your centre have access to internet? ☐ Yes ☐ No			

5. Human resource:

i) The count is the actual personnel in your centre and **DO NOT INCLUDE LOCUM STAFF**.

a.	Registered Nurse in your centre.			
	i) Number **with** Renal Nursing Certificate :		ii) Number **without** Renal Nursing Certificate:	
b.	Registered Medical Assistant in your centre.			
	i) Number **with** Renal Nursing Certificate :		ii) Number **without** Renal Nursing Certificate:	
c.	Dialysis Nursing Aides in your centre.			
	i) Number **with** certificate of haemodialysis training:		ii) Number **without** certificate of haemodialysis training:	

6. Other RRT services:

a. If your centre provides CAPD service, please answer the following question:

Number of CAPD patients currently on follow-up?

Name of Coordinator:…… Mykad No……/……/……

☐ Registered Nurse ☐ Registered Assistant Medical Officer ☐ Others, specify:

b. If your centre provides post transplant follow-up care service, please answer the following question:

Number of renal transplant patients currently on follow-up?

Name of Coordinator:…… Mykad No……/……/……

☐ Registered Nurse ☐ Registered Assistant Medical Officer ☐ Others, specify:……..