An tSeirbhís Náisiúnta Scagthástála
National Screening Service

CervicalCheck
AN CLÁR NÁISIÚNTA SCAGTHÁSTÁLA CEIRBHEACS
THE NATIONAL CERVICAL SCREENING PROGRAMME

Application form for Cervical Screening Education programme (experienced sampletakers)

Please note this application form will only be accepted in digital format & returned via email to stu@cervicalcheck.ie

Part A to be completed by Applicant

Applicant Name: _____

Applicant MCRN/NMBI Pin: _____

GP ☐ Registered General Nurse ☐ Registered Midwife ☐
(please note that only Nurses & Midwives registered on these divisions are eligible to perform cervical screening)

GP Registrar ☐

GP Specialist Scheme Name: _____

GP Specialist Scheme Location: _____

Practice Address & Eircode:

Practice Tel No: _____

Applicant Mobile: _____

Applicant Email: _____

Do you have a specific learning disability that may affect your studies?

Yes ☐ No ☐ if yes a member of the STU team will be in contact.

I consent to the use of this email for administrative communications from *CervicalCheck* Yes ☐ No ☐
(Administrative communications will include information on policy updates, study days, newsletters etc)

The trainee acknowledges and agrees that programme cervical screening tests will be carried out under the clinical responsibility of the general practitioner (GP) pursuant to the contract with registered medical practitioners for the provision of a primary care based cervical screening service. The Contracted GP shall receive payment for all such tests carried out.

Signature of Trainee: _____

Date: _____

Part B Trainee supervision to be completed by CRD

- I am aware that a CervicalCheck appointed clinical trainer will visit the trainee in my practice. ☐
- In modelling best practice, I understand that the CervicalCheck appointed clinical trainer may take a cervical screening test in my practice. ☐
- I agree to supervise the trainee and support the policies and protocols of CervicalCheck – The National Screening Programme. ☐
- The Clinically Responsible Doctor/CRD i.e. the contract holder with CervicalCheck must sign the below section: ☐

Please Note: CervicalCheck appointed clinical trainers are covered by clinical indemnity.

Name of Clinically Responsible Doctor (CRD)/contract holder:

MCRN: _____

Signature of Clinical Responsible Doctor:

Date of Signature: _____

Clinical Supervisor (CS) or CRD Name

MCRN/NMBI: _____

CS/CRD Email:

I, confirm that I have completed the Cervical Screening Education Programme: ☐

Or

have completed 3 clinical updates: ☐

Signature of CS/CRD

If the applicant is the CRD and has no access to a supervisor, the CervicalCheck clinical trainer will act as clinical supervisor.

All mandatory requirements will be verified prior to the student been offered a place on the course

Privacy Notice: Your personal details that you provided will be kept on file within the screening training unit (STU) to enable us to facilitate the Cervical Screening Education Programme.