CervicalCheck
AN CLÁR NÁISIÚNTA SCAGTHÁSTÁLA CEIRBHEACS
THE NATIONAL CERVICAL SCREENING PROGRAMME

Family Planning Clinic/ Well Woman Centre Health Professional Registration Form

(Health Professionals include GPs, Assistant GPs, Registered Nurses and Trainee GPs, -referred to hereunder as qualified persons)

The Qualified Person acknowledges and agrees that Programme screening tests will be carried out under the clinical responsibility of the Clinical Director below pursuant to the Contract for the Provision of Cervical Screening Services entered into by the Clinical Director on behalf of the Clinic/Centre with the National Screening Service. The contracted Clinic/Centre shall receive payment for all such tests carried out.

Health Professional

Name of doctor or nurse (BLOCK CAPITALS) _____ Male ☐ Female ☐

Clinic/Centre Name (BLOCK CAPITALS) _____

Please specify Doctor ☐ Assistant Doctor ☐ Registered Nurse ☐

Email address _____

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

I have completed the ***'CervicalCheck in Practice'*** online eLearning module ☐

Medical Council Registration Number (MCRN) or Nursing & Midwifery Board of Ireland Number (NMBI) ☐☐☐☐☐☐☐

Signature of the Doctor / Nurse _____ Date _____

Clinical Director

Name (BLOCK CAPITALS) _____

Medical Council Registration Number (MCRN) ☐☐☐☐☐☐☐

PCRS / GMS Number of Clinic/Centre ☐☐☐☐☐☐☐

Signature of Clinical Director _____ Date _____

The Qualified Person and/or the Clinical Director will be notified when the QP registration process has been completed. It is important to notify Programme Administration Office of any changes to your details or professional registration status.

For office use only

Date stamp

Check 1 _____ Date _____

Check 2 _____ Date _____

Assigned Clinic ID | C | L | I | N | | | | |

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