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 Registration Form for GP Registrars

Please type into this form and return via email to stu@cervicalcheck.ie

Part A to be completed by Applicant

Applicant Name: _____

Applicant MCRN: _____

GP Registrar ☐

GP Specialist Scheme Name: _____

GP Specialist Scheme Location: _____

CervicalCheck Workshop Date: _____

Practice Address & Eircode:

Practice Tel No: _____

Applicant Mobile: _____

Applicant Email: _____

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

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

The applicant and the Clinically Responsible Doctor will be notified when the registration process has been completed.

Please email admin@cervicalcheck.ie if there is any changes to your work location or if you retire.

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)

Mandatory Requirements in order to register as sampletaker requires competion of CervicalCheck in Practice in Primary Care. This requirement is covered during the workshop and does not need yo be completed on NSSResources.ie in advance of the workshop. ☐

The registered doctor or applicant acknowledges and agrees that CervicalCheck 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 Applicant: _____
(typed signature accepted)

Date: _____

Part B Trainee supervision to be completed by Clinically Responsible Doctor (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 CRD i.e. the contract holder with CervicalCheck must sign the below section:

Please Note: CervicalCheck-appointed Clinical Trainers are covered by HSE clinical indemnity.

Name of Clinically Responsible Doctor/Contract Holder/
Clinical Supervisor:

_____

Medical Council Number of CRD: _____

PCERS (GMS) Number: _____

Signature of Clinically Responsible Doctor:

_____

Date of signature: _____
(typed signature accepted)

Privacy Notice: The personal details that you provide will be kept on file within the Screening Training Unit (STU) to enable us to facilitate your participation on the Cervical Screening Education Programme and your registration as a CervicalCheck sampletaker. It will not be used for any other purposes. If you have any questions about how your personal data is processed or to exercise your rights under the GDPR please contact dataprotection@screeningservice.ie