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| **Supervision Agreement Form-GP Reg Trainee** |
| **Please note this registration form will only be accepted in digital format.****Submit completed forms via email to** **stu@cervicalcheck.ie** |
| **Part A: GP Reg Trainee** | **Part B: Clinically Responsible Doctor (CRD).****\*The CRD is the contract holder with CervicalCheck** |
| * To be completed by the GP Reg Trainee when ready to undertake the clinical component of training and prior to the commencement of the self-audit.

**GP Reg Trainee Name:** Click or tap here to enter text.**MCRN**: Click or tap here to enter text.**Mobile Number:** Click or tap here to enter text.**Email Address:** Click or tap here to enter text.**Practice Address & Eircode:** **Practice Telephone No:** Click or tap here to enter text.**GP Training Scheme Location:** Choose an item.**Cervical screening theory session completed (via release day):****Yes**: [ ]  **No**: [ ]  **Date**: Click or tap to enter a date.I have completed the “**CervicalCheck in Practice”** online eLearning module: **Yes**:[ ]  **No:** [ ]  **Date**: Click or tap to enter a date.*The registered Sampletaker (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 GP Trainee: ­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date:** Click or tap to enter a date. | * 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 support the policies and protocols of CervicalCheck – The National Cervical Screening Programme. [ ]

*Please note CervicalCheck-appointed Clinical Trainers are covered for clinical indemnity.***Name of \*CRD:** Click or tap here to enter text.**MCRN Number:** Click or tap here to enter text.**Signature of CRD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date:** Click or tap to enter a date.***Privacy Notice:*** *Any personal details provided will be kept on file within the Screening Training Unit (STU) to enable facilitation of the Cervical Screening Education Programme.* |