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 type into this application form and return 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)

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.

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 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: _____

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 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 HSE clinical indemnity.

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

MCRN: _____

Name of Clinically Responsible Doctor:

Date of Signature: _____

Clinical Supervisor Name if different to CRD:

MCRN/NMBI: _____

CS/CRD Email:

*The following **mandatory requirement** must be completed and will be verified in order for a person to be deemed eligible to act as a supervisor for the trainee.*

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

Or

I confirm I have completed the two clinical updates on NSS resources: ☐ (Please attach certificates of completion)

Signature of CS/CRD:

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