



An tSeirbhís Náisiúnta Scagthástála
National Screening Service



Application Form for Cervical Screening Education Programme (Novice Sampletakers) Registration Form for Healthcare Professionals

Please type into this digital form and 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.

**The applicant and the Clinically Responsible Doctor (CRD) 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)

The locations of the upcoming workshops are outlined in the schedule
of learning events.

Please indicate below your desired location.

Location: _____

Date: _____

Mandatory Requirements in order to register as a sampletaker:

I have completed the online "CervicalCheck in practice" clinical
update and attached a copy of the certificate of completion. Yes

The registered doctor or nurse/midwife (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 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 CRD/contract holder:

Medical Council Number of CRD: _____

PCERS (GMS) Number: _____

Name of Clinically Responsible Doctor:

Date of Signature: _____

Clinical Supervisor (CS) if different to CRD:

MCRN/NMBI Pin: _____

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 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