Part A: To be completed by trainee

Trainee Name_____ MCRN/NMBI_____

Male☐ Female☐ GP:☐ Assistant GP: ☐ Reg Nurse:☐ GP Trainee ☐

Home Address:

Practice Address

Practice Tel No:_____

Mobile Tel: _____

Email Address: _____

I consent to use of email for administration and communication of CervicalCheck information ☐

Can you be contacted via text message? Yes ☐ No ☐

Do you have a specific learning disability that may affect your studies: ☐

I confirm that I wish to register for the following course: Yes ☐ No ☐

Course Details

Title: <<Insert Course Title & Academic Provider>>_____

Date <<Insert Date>>_____

Mandatory Requirement:

I have completed the '**CervicalCheck in Practice'** online eLearning module on the following date: _____

The registered doctor or nurse (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 for the Provision of Cervical Screening Services entered into by the GP and the National Screening Service. The Contracted GP shall receive payment for all such tests carried out.

Signature of Trainee:_____ **Date**:_____

Part B: To be completed by the clinically responsible GP/Doctor (contracted GP)

- 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 National Cervical Screening Programme.
- The Clinically Responsible Doctor/CRD i.e. the contract holder with CervicalCheck must sign the following section:

Name of Clinically Responsible GP/Doctor: _____

Medical Council Number/PCRS/GMS number: _____

Signature of Clinically Responsible Doctor: _____

Do you wish to include the trainee's name on the CervicalCheck website at your practice location(s):
Please tick: Yes ☐ No☐

Date of signature: _____

The doctor or nurse and/or the General Practitioner will be notified when the registration process has been completed.

Please Note: CervicalCheck appointed clinical trainers are covered by clinical indemnity.

For CervicalCheck office use only:

CervicalCheck in Practice completed: ☐

Professional registration verified: ☐

Signature of correct CRD: ☐

All mandatory registration requirements validated by: Name: Date: